64TH ANNUAL MEETING · CHICAGO · SEPT. 17-20

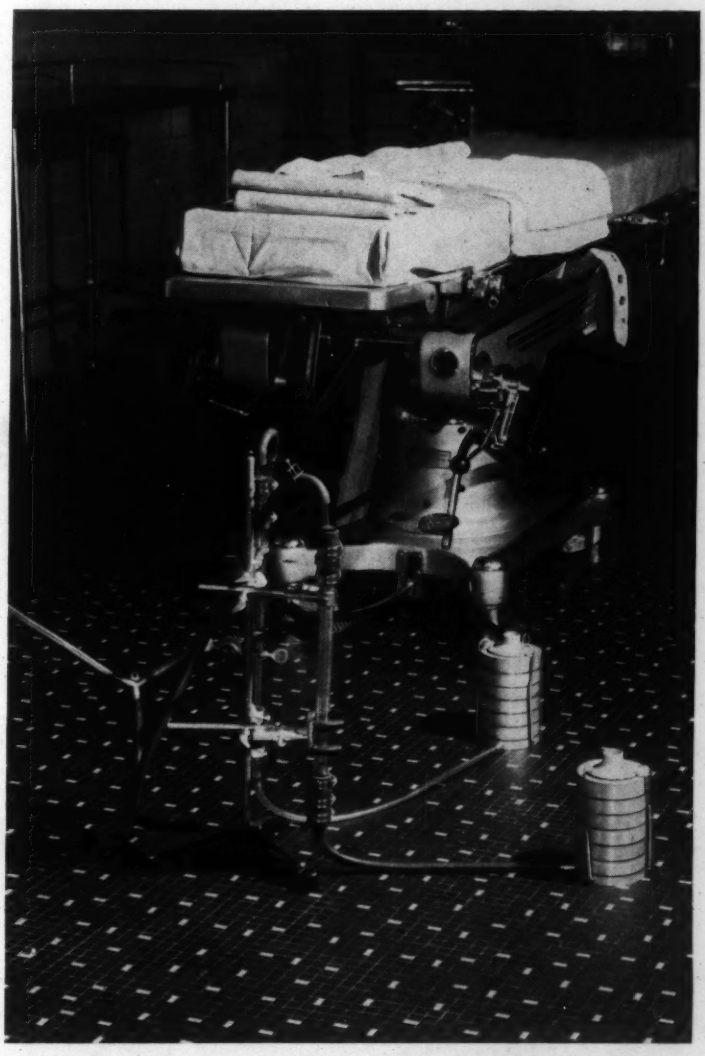
HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

NOVEMBER 1, 1961

—Bed supply and hospital distribution

—The case for coordinated hospital planning



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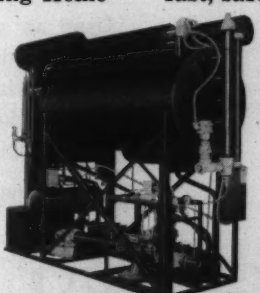

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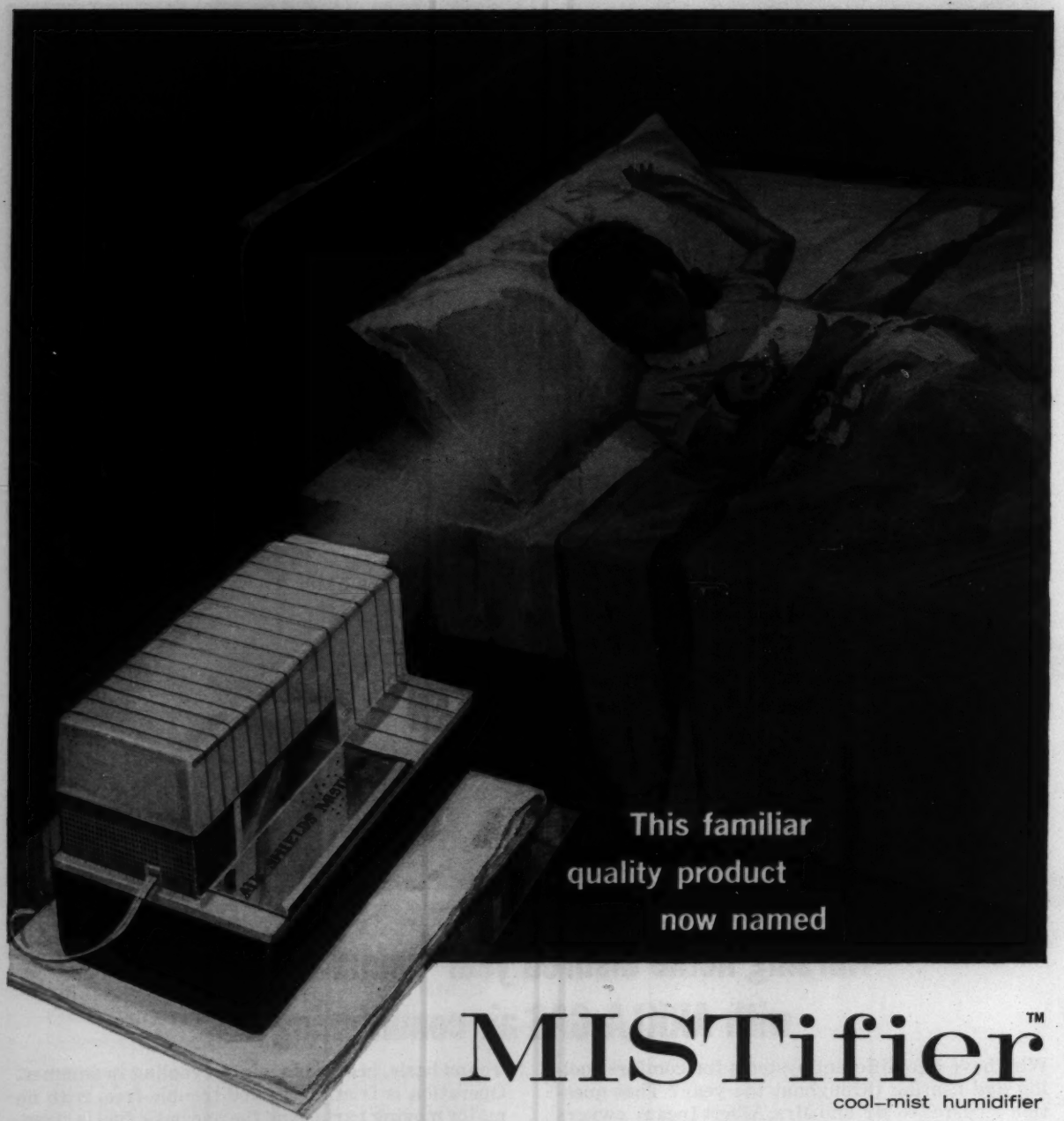

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Volume 35 **Number 21** **November 1, 1961**

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special report

Graduate Medical Education in the United States, 1960-1961 17

articles

Bed Supply and Hospital Utilization: A Natural Experiment ..... *Milton I. Roemer, M.D.* 36

The Case for Coordinated Hospital Planning. Part 1—The Need ..... *Rosson L. Cardwell and Karl S. Klicka, M.D.* 43

Recirculation of Air in the Surgical Suite .... *Harvey R. Bernard, M.D., William R. Cole, M.D., D.Sc., and James C. Claywell, B.S.M.E.* 46

How Not to Be an Effective Supervisor ..... *Edith Arlen* 51

Check List for Educational Planning
American Hospital Association Institute Schedule for 1962 53

Measuring Hospital Capacity for Modern Patient Care ..... *Paul A. Lembcke, M.D., and Eleanor Poland, Ph.D.* 57

Open-Staff Policy Opens the Door to Improved Psychiatric Therapy ..... *Morris B. Squire* 64

Management-Oriented Purchasing ..... *W. R. Williams* 68

Dietary Progress in the Smaller Hospital ..... *Anna Katherine Jernigan* 74

Managing the Engineering and Maintenance Department ..... *Herbert M. Gaskill* 96

departments

Engineering and Maintenance .. 96
Food Service and Dietetics 74
Professional Practice 64
Purchasing 68

regular features

Association Section 126
Book Reviews 101
Calendar of Association and Allied Meetings 6
Editorial Notes 35
Equipment and Supply Review .. 88
Introducing the Authors 12
Law in Brief 107
News 113
Officers, Trustees and Councils of the American Hospital Association 10
Opinions and Ideas 31
Personnel Changes 105
Service from Headquarters 29
Washington Report 111

cover

THE ANDERSEN multistage sampler, shown in this view of an operating room in Barnes Hospital, St. Louis, Mo., was used as the collecting device in the four-month study of recirculated air which is reported in the article beginning on page 46. Cover photo by courtesy of Barnes Hospital. (Other photo credits in this issue are listed on page 134.)

Classified Advertising 133
Index to Advertisers 134

HOSPITALS is published the first and sixteenth of each month by the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill. TEL. WHitehall 4-4350. Second class postage paid at Chicago, Illinois. SUBSCRIPTION RATES: $5 for 1 year; $12 for 3 years. Single copies 30 cents, except the two-part August 1, Guide Issue $2.50. (Foreign and Pan-American add $1 per year for postage.) CHANGE OF ADDRESS: Notice should include the old as well as the new address including postal zone number. Four weeks' notice is required. The local postmaster should be notified.

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1. Lipp, R.G.: Habitual Abortion—Treatment with Parenteral Medroxyprogesterone Acetate, to be published.

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hospital association meetings

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NATIONAL MEETINGS

1962

Jan. 31-Feb. 1—**Midyear Conference of Presidents and Secretaries,** Chicago (AHA Headquarters)

Sept. 17-20—**64th Annual Meeting,** Chicago (McCormick Place)

MEETING AND INSTITUTE CALENDAR

THROUGH APRIL 1962

(American Hospital Association Institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. ***Other organizations in the health field are shown in ITALICS.)***

NOVEMBER

1-3 Indiana Hospital Association, French Lick (French Lick Hotel)

2-3 Oklahoma Hospital Association, Tulsa (Mayo Hotel)

2-4 **Hospital Directors of Medical Education,** Chicago (AHA Headquarters)

6-8 ***American Occupational Therapy Association,*** Detroit (Sheraton-Cadillac Hotel)

6-8 **Hospital Pharmacy (Specialized),** Chicago (AHA Headquarters)

6-9 ***American Association of Inhalation Therapists,*** Buffalo, N.Y. (Statler-Hilton Hotel)

6-10 **Physical Therapists,** Miami Beach (Deauville Hotel)

8-10 Maryland-D.C.-Delaware Hospital Association, Washington (Shoreham Hotel)

9-10 Kansas Hospital Association, Hutchinson (Baker Hotel)

9-10 Minnesota Hospital Association, Minneapolis (Leamington Hotel)

9-10 Virginia Hospital Association, Richmond (John Marshall Hotel)

13-15 ***Association of American Medical Colleges,*** Montreal, Quebec, Canada (Queen Elizabeth Hotel)

13-17 ***American Public Health Association,*** Detroit (Cobo Hall)

13-17 **Hospital Housekeeping (Advanced),** Chicago (AHA Headquarters)

13-17 **Dietary Department Administration,** Boston (Somerset Hotel)

14-16 **Directors of Hospital Volunteers (Basic),** Denver (Cosmopolitan Hotel)

26-Dec. 1 ***Radiological Society of North America,*** Chicago (Palmer House)

27-30 **Operating Room Administration (Advanced),** Indianapolis (Sheraton-Lincoln Hotel)

28-30 **Hospital Dental Service (Advanced),** Chicago (AHA Headquarters)

30-Dec. 1 Illinois Hospital Association, Springfield (St. Nicholas Hotel)

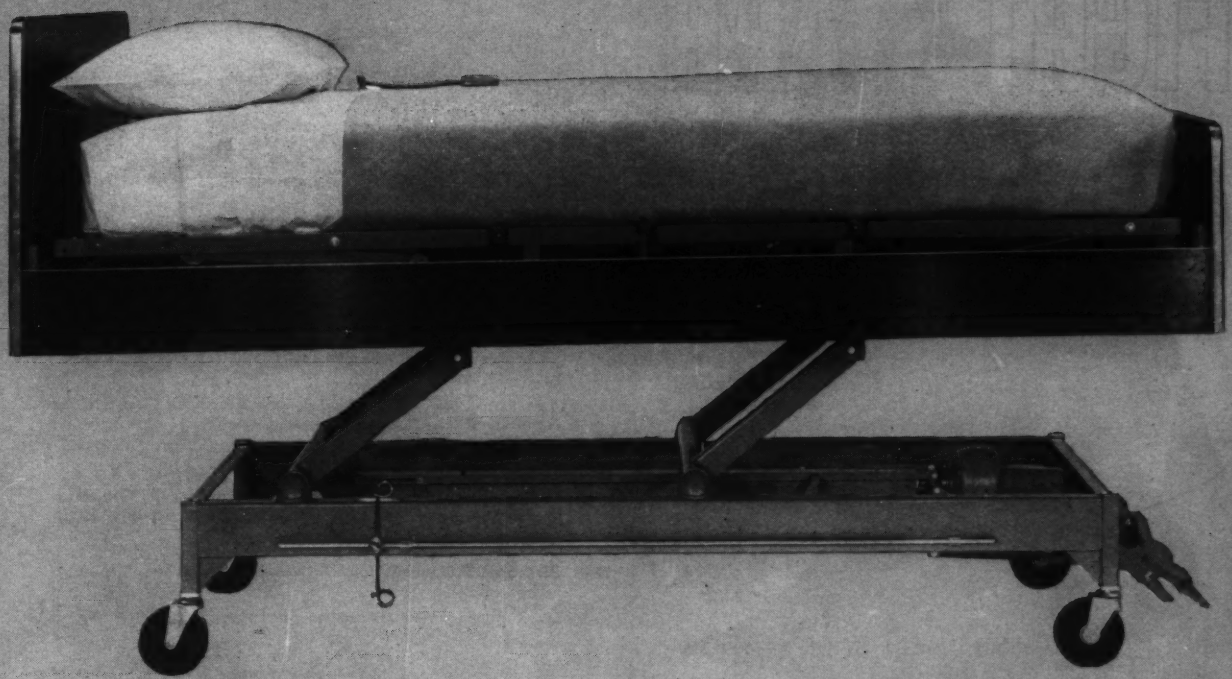
DECEMBER

11-15 **Hospital Design and Construction,** Los Angeles (Statler Hilton)

13-15 **Medical Record Librarian's Institute on Medical-Legal-Principles of Medical Record Administration (Advanced),** Chicago (AHA Headquarters)

26-31 ***American Association for the Advancement of Science,*** Denver (Denver Hilton)

(Continued on page 8)



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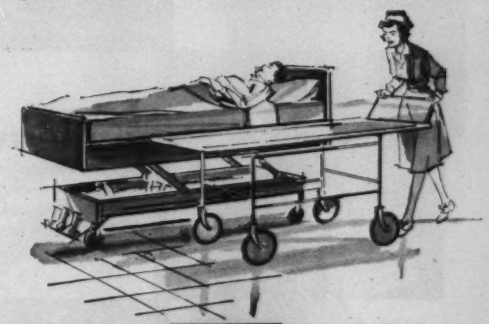

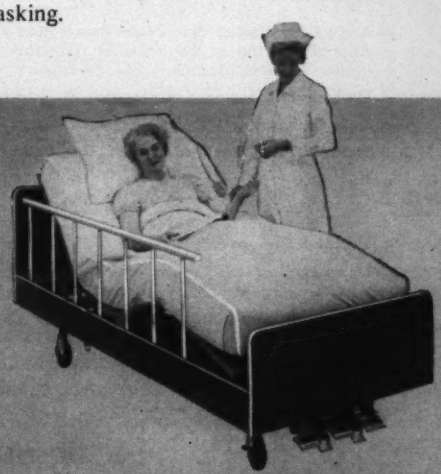

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JANUARY

8-12 **Dietary Department Administration,** Pittsburgh (Webster Hall Hotel)

17-19 Alabama Hospital Association, Mobile (Admiral Semmes Hotel)

22-24 *National Association of Private Psychiatric Hospitals,* Sarasota, Fla. (Colony Beach Resort)

22-26 **Nursing Service Administration,** Memphis, Tenn. (Claridge Hotel)

26 South Carolina Hospital Association, Columbia (Wade Hampton Hotel)

31-Feb. 1 **American Hospital Association Midyear Conference of Presidents and Secretaries,** Chicago (AHA Headquarters)

FEBRUARY

1-3 *American College of Hospital Administrators Congress on Administration,* Chicago (Morrison Hotel)

5-9 **Nursing Service Administration,** San Francisco (Sheraton-Palace Hotel)

5-9 **Special Institute for Medical Record Librarians on Organization and Management,** Chicago (AHA Headquarters)

12-14 **Budgeting,** Chicago (AHA Headquarters)

19-21 **Personnel Administration (Advanced),** Louisville, Ky. (Kentucky Hotel)

26-March 2 *American Protestant Hospital Association,* Chicago

MARCH

5-8 **Emergency Room Nursing Service Management,** Chicago (AHA Headquarters)

12-14 **Directors of Hospital Volunteers (Advanced),** Chicago (AHA Headquarters)

13-16 **Hospital Purchasing (Advanced),** Baton Rouge, La. (Capitol House Hotel)

14-16 Louisiana Hospital Association, Baton Rouge (Capitol House Hotel)

15 Wisconsin Hospital Association, Milwaukee (Schroeder Hotel)

19-21 **Labor Relations,** Chicago (AHA Headquarters)

20-22 Kentucky Hospital Association, Louisville (Kentucky Hotel)

26-28 New England Hospital Assembly, Boston (Statler-Hilton Hotel)

26-29 **Evening and Night Nursing Service Administration,** Chicago (AHA Headquarters)

27-30 **Nursing Home Administration,** Miami Beach, Fla. (Seville Hotel)

APRIL

1-6 *Annual Meeting of Blue Cross Association Members and the Annual Meeting of the National Association of Blue Shield Plans,* Colorado Springs, Colo. (Broadmoor Hotel)

2-4 **Methods Improvement (Advanced),** Baltimore (Emerson Hotel)

2-5 Ohio Hospital Association, Toledo (Toledo Sports Arena)

9-13 **Staffing Departments of Nursing Units,** Chicago (AHA Headquarters)

12-13 Carolina-Virginias Hospital Conference, Roanoke, Va. (Hotel Roanoke)

16-20 **Hospital Engineering, Chicago** (AHA Headquarters)

25-27 Midwest Hospital Association, Kansas City, Mo. (Municipal Auditorium)

25-27 Southeastern Hospital Conference, New Orleans (Municipal Auditorium)

30-May 2 Tri State Hospital Assembly, Chicago (Palmer House)

30-May 3 **Obstetrical Nursing Service Administration,** Buffalo, N.Y. (Statler Hilton Hotel)

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Rosson L. Cardwell, associate director and director of research for the Hospital Planning Council for Metropolitan Chicago and **Karl S. Klicka, M.D.,** executive director of the council, clarify the concept of long-range planning in the first of three articles on coordinated planning, starting on page 43.

MR. CARDWELL

Mr. Cardwell, who holds an M.S. in economics from the University of Chicago, has been in his present position since 1959. Prior to this, he was associated with the management consultant firm of Booz, Allen & Hamilton, Chicago, for four years, as a consultant and project director of a research study of institutional long-range planning. Mr. Cardwell served as executive director of the Cowles Commission for Research in Economics, University of Chicago, from 1952 to 1955, at which time he was also the executive secretary of the Econometric Society.

Karl S. Klicka, M.D., was appointed executive director of the Hospital Planning Council for Metropolitan Chicago in 1959. He was formerly the director of Presbyterian-St. Luke's Hospital, Chicago, and director of the old Presbyterian Hospital from 1952 until the merger of the two hospitals in 1956, when he became director of the combined hospitals. Prior to 1954, he served for three years as director of the St. Barnabas Hospital, Minneapolis and for five years as director of Women's Hospital, New York City.

Dr. Klicka received his M.D. degree from Western Reserve University and his M.S. in hospital administration from the University of Chicago. He is a past president of the Chicago Hospital Council and the Minneapolis Hospital Council.

Eleanor Poland, Ph.D., and **Paul A. Lembcke, M.D.,** describe a simple method for determining the capacity of all hospital departments in their article beginning on page 57.

Dr. Poland, a medical economist, is project director for the Regional Health and Hospital Study, Community Studies, Inc., Kansas City, Mo. She joined Community Studies as a research associate in 1952 after gaining experience as a research economist for Brookings In-

DR. POLAND

DR. LEMBCKE

stitution and various government agencies and as a research medical economist for the U.S. Public Health Service and the American Pharmaceutical Association. Dr. Poland received her A.B., A.M. and Ph.D. degrees from Radcliffe College and Harvard University.

Paul A. Lembcke, M.D., is professor of preventive medicine and public health at the University of California School of Medicine. He is a consultant to the World Health Organization; Community Studies, Inc., and the Pacific State Hospital, Pomona, Calif. Past positions held by Dr. Lembcke in his career in medicine and public health have included director of study, New York State Commission on Medical Care; associate director, Rochester Regional Hospital Council, and associate professor of public health administration, Johns Hopkins University. Dr. Lembcke received his M.D. degree from the University of Rochester and an M.S. degree in public health from Johns Hopkins University.

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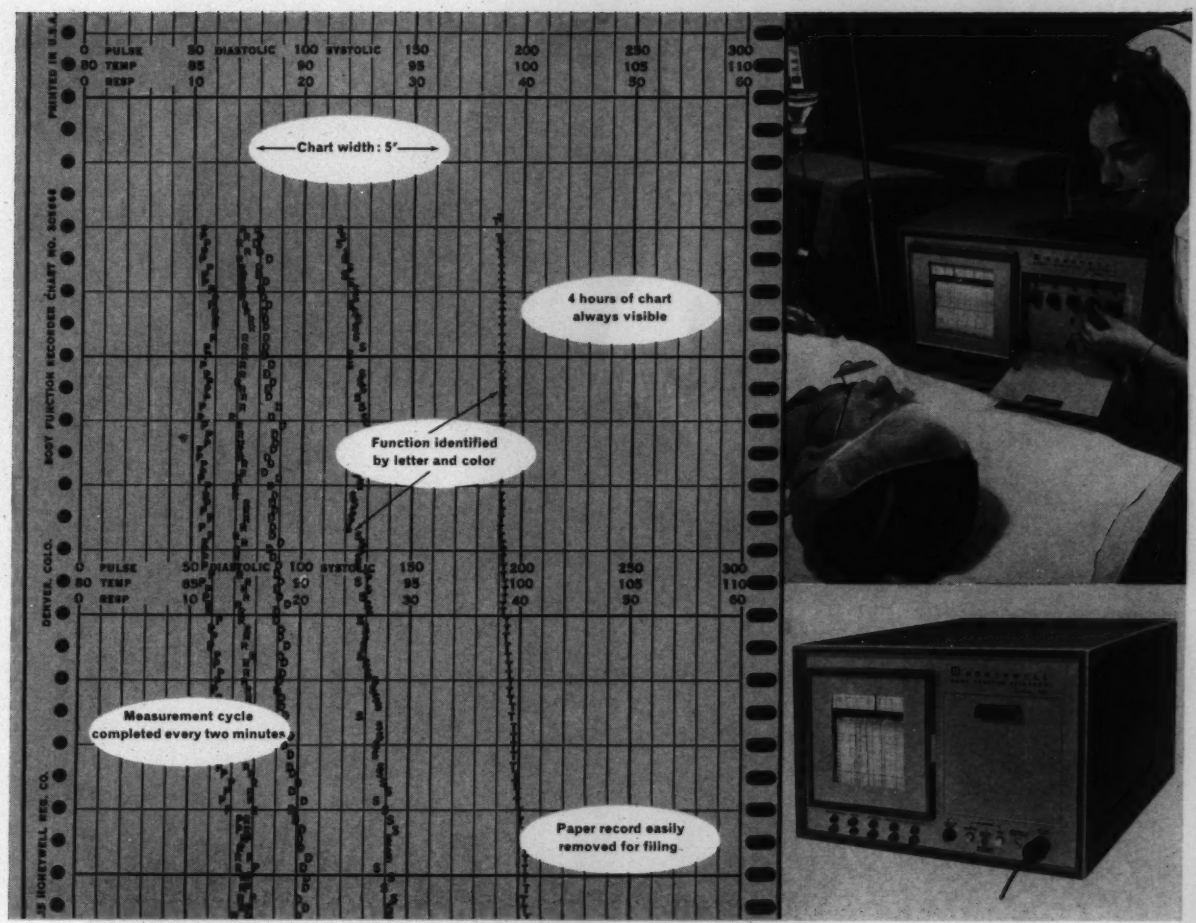
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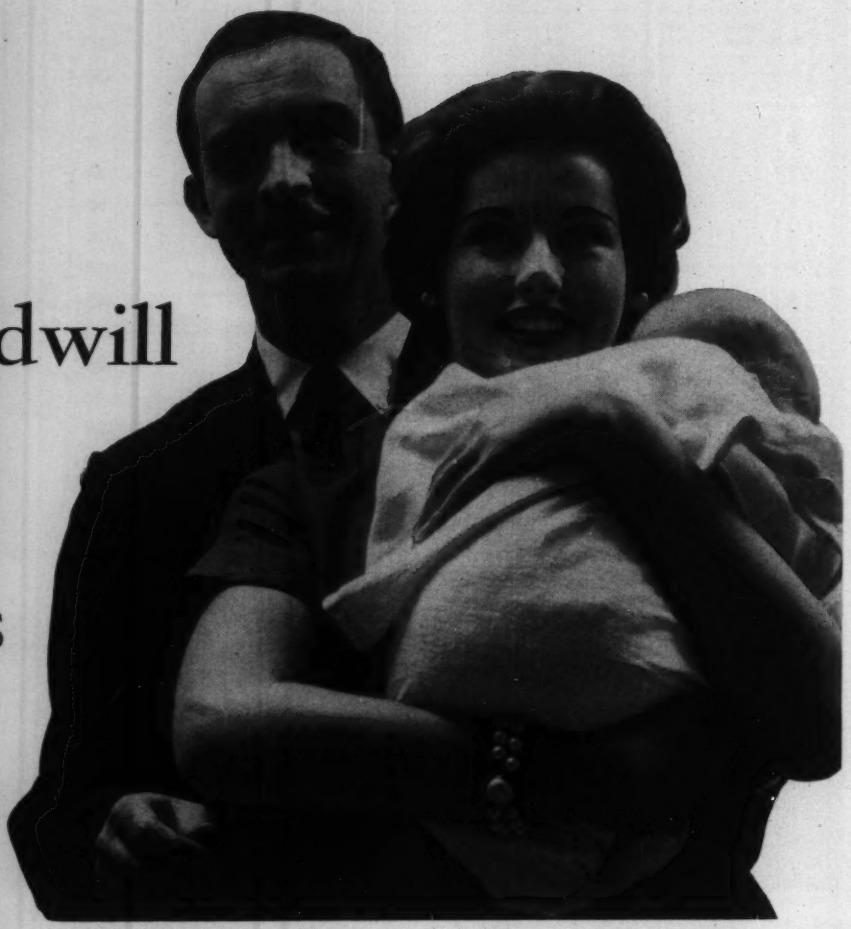

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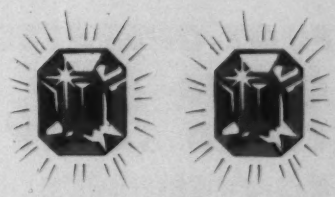

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SPECIAL REPORT

Graduate Medical Education in the United States, 1960-1961

- Foreign medical graduates constituted 26 per cent of all interns and residents serving in U.S. hospitals during the academic year of 1960-61
- The 1445 hospitals with approved training programs make up 21 per cent of all hospitals, but contain only 48 per cent of the hospital beds in the United States
- The 352 hospitals affiliated with medical schools are only 27 per cent of all hospitals approved for residency training, but they offer 54 per cent of available residencies

These are some of the statistics of graduate medical education reported in the American Medical Association's 35th Annual Report on Graduate Medical

Table 1—Number of Internships, by Census Region and State, 1960-1961

Census Region and State	No. of Approved Programs	No. of Hospitals	No. of Internships		
			Filled Sept. 1, 1960	Vacant Sept. 1, 1960	Percentage Filled
New England					
Connecticut	24	20	180	49	79
Maine	3	3	13	11	54
Massachusetts	54	40	315	120	72
New Hampshire	1	1	16	..	100
Rhode Island	7	7	50	18	73
Vermont	3	2	12	..	100
Totals	92	73	586	198	75
Middle Atlantic					
New Jersey	44	42	294	136	68
New York	185	111	1,492	356	81
Pennsylvania	82	78	618	322	66
Totals	311	231	2,404	814	75
East North Central					
Illinois	56	47	439	206	68
Indiana	17	14	125	47	73
Michigan	44	41	403	218	65
Ohio	69	54	539	287	65
Wisconsin	26	21	104	113	48
Totals	212	177	1,610	871	65
West North Central					
Iowa	7	7	72	16	82
Kansas	12	6	65	27	71
Minnesota	20	15	187	71	72
Missouri	39	24	234	191	55
Nebraska	10	10	42	45	48
North Dakota	2	2	3	13	19
South Dakota	3	3	14	4	78
Totals	93	67	617	367	63
South Atlantic					
Delaware	5	4	18	21	46
District of Columbia	21	12	240	34	87
Florida	23	17	206	43	83
Georgia	24	18	182	58	76
Maryland	47	22	227	100	69
North Carolina	33	13	150	82	65
South Carolina	10	7	77	27	74
Virginia	24	18	178	61	74
West Virginia	11	11	37	55	40
Totals	198	122	1,315	481	73
East South Central					
Alabama	14	6	65	35	65
Kentucky	15	10	64	71	47
Mississippi	2	2	31	4	88
Tennessee	20	15	218	50	81
Totals	51	33	378	160	70
West South Central					
Arkansas	9	3	43	15	74
Louisiana	12	10	161	84	66
Oklahoma	11	7	74	22	77
Texas	38	25	366	75	83
Totals	70	45	644	196	77
Mountain					
Arizona	6	6	40	27	60
Colorado	17	13	137	42	76
Montana	1	1	4	..	100
New Mexico	1	1	12	..	100
Utah	12	7	104	25	81
Totals	37	28	297	94	76
Pacific					
California	63	51	884	136	87
Hawaii	4	4	68	9	88
Oregon	8	7	65	35	65
Washington	17	15	145	39	79
Totals	92	77	1,162	219	84
Territories and Possessions					
Canal Zone	1	1	13	3	81
Puerto Rico	10	10	89	29	75
Totals	11	11	102	32	76
Grand Totals	1,167	864	9,115	3,432	73

Education in the United States for the academic year of 1960-61 (*J.A.M.A.*, 177:620-633, Sept. 2, 1961).*

FEWER INTERNSHIPS OFFERED

A significant finding reported is that the number of internships offered decreased during 1960. This indicates, according to the authors of the report,** that the anticipated leveling-off of programs is imminent. Approved hospitals totaled 864, one less than for the previous year; positions they offered totaled 12,549, or 31 fewer than last year.

Of the internships programs offered, 70 per cent were rotating, 24 per cent were straight and 6 per cent were mixed. There was little change in the number of rotating and straight internships, but the number of mixed doubled from 33 to 69. Although the total number decreased by 31, only 73 per cent were filled, which is 1137, or 9 per cent, less than last year. The authors of the report attribute this to the fact that 792 fewer foreign medical graduates were serving internships this year.

CONTROL AND AFFILIATION

Of the total internships available, 64 per cent were offered by nongovernmental hospitals operated not for profiit by churches or corporations; 30 per cent were offered by nonfederal governmental hospitals; 5 per cent by federal hospitals, and 1 per cent by proprietary hospitals.

The nonprofit, nongovernmental hospitals filled 67 per cent of the available positions, 12 per cent less than last year; the nonfederal governmental hospitals filled 80 per cent of the positions available, 4 per cent less than last year; the federal hospitals filled

*This year the detailed lists of approved programs were omitted from the report, as were the "Essentials of an Approved Internship" and the "Essentials of Approved Residencies", the requirements of the American Specialty Boards and the details of the National Intern Matching Program. Instead, all these will be included in the *Directory of Approved Internships and Residencies* which will be published separately and distributed without cost to all institutions, organizations and agencies having need for it.

**John C. Nunemaker, M.D., Willard V. Thompson, M.D., Ralph E. Adams, M.D., and Mrs. Rose Tracy.

Table 2—Number of Residencies, by Census Region and State, 1960-1961

Census Region and State	No. of Approved Programs	No. of Hospitals	No. of Residencies: Filled Sept. 1, 1960	No. of Residencies: Vacant Sept. 1, 1960	No. of Residencies: Percentage Filled
New England					
Connecticut	107	31	516	86	86
Maine	15	3	20	27	42
Massachusetts	236	75	1,323	132	91
New Hampshire	12	2	66	18	78
Rhode Island	27	12	102	13	89
Vermont	39	4	96	17	85
Totals	436	127	2,123	293	88
Middle Atlantic					
New Jersey	146	59	489	94	84
New York	810	185	4,863	398	92
Pennsylvania	450	114	1,955	412	82
Totals	1,406	358	7,307	904	89
East North Central					
Illinois	310	67	1,477	212	87
Indiana	74	18	320	101	76
Michigan	232	56	1,406	195	88
Ohio	362	79	1,785	286	86
Wisconsin	103	25	480	118	80
Totals	1,081	245	5,468	912	86
West North Central					
Iowa	43	11	283	52	84
Kansas	41	11	237	57	81
Minnesota	109	24	1,067	113	90
Missouri	159	33	884	158	85
Nebraska	35	13	106	61	63
North Dakota	7	3	16	..	100
South Dakota	6	3	11	3	78
Totals	400	98	2,604	444	85
South Atlantic					
Delaware	16	5	28	13	68
District of Columbia	110	16	680	88	88
Florida	76	19	434	39	92
Georgia	95	20	474	88	84
Maryland	144	34	893	79	92
North Carolina	104	20	532	66	89
South Carolina	27	6	85	30	74
Virginia	104	30	496	93	84
West Virginia	42	17	103	43	70
Totals	718	167	3,725	539	87
East South Central					
Alabama	55	10	201	76	72
Kentucky	66	19	279	64	81
Mississippi	32	8	87	47	65
Tennessee	121	28	562	81	87
Totals	274	65	1,129	268	81
West South Central					
Arkansas	26	7	130	30	81
Louisiana	91	17	584	48	92
Oklahoma	73	12	194	40	83
Texas	240	43	1,135	172	87
Totals	430	79	2,043	290	87
Mountain					
Arizona	22	6	81	7	92
Colorado	95	18	539	59	90
New Mexico	13	4	14	28	33
Utah	51	9	203	32	86
Totals	181	37	837	126	87
Pacific					
California	453	98	2,330	383	86
Hawaii	23	9	65	12	84
Oregon	44	8	209	42	83
Washington	95	19	329	27	92
Totals	615	134	2,933	464	86
Territories and Possessions					
Canal Zone	7	1	20	2	91
Puerto Rico	41	13	167	22	88
Totals	48	14	187	24	89
Grand Totals	5,589	1,324	28,356	4,264	87

96 per cent, 1 per cent more than last year, and the proprietary hospitals filled 72 per cent, 9 per cent less than last year.

Of the 12,549 available positions, 4779 (38 per cent) are in hospitals affiliated with medical schools; 7770 (62 per cent) are in nonaffiliated hospitals. According to the authors of the report, approximately 50 per cent of American medical school graduates elect their internships in nonaffiliated hospitals.

The report also indicates that bed size influences intern recruitment in no uncertain manner. Both medical school-affiliated and nonaffiliated hospitals with more than 500 beds were more successful in attracting interns than those having fewer than 500 beds. The least successful were the nonaffiliated hospitals of less than 200 beds.

INTERNSHIPS AND GEOGRAPHY

The number of internships by census region and state, both available and filled, are shown in Table 1, page 17. All regions experienced a drop in the number of positions filled except the West South Central region, and the gain there was only 1 per cent.

Monthly stipends again increased, but the nonaffiliated hospitals averaged $41 per month more than the affiliated hospitals. The average for the first was $219 per month, and for the latter $178 per month. Among programs providing other benefits, 50 per cent included Blue Cross coverage or other type of hospitalization; 37 per cent included liability insurance.

DATA ON HOSPITAL RESIDENCIES

A total of 5589 approved programs offering a total

Table 3—Foreign Physicians in Approved Graduate Training Programs by Census Region and State, 1960-1961

Census Region and State	Total Intern and Resident Programs Approved	Total Intern and Resident Positions Filled	Total* Foreign Physicians Serving	Percentage of Foreign Physicians in Filled Positions
New England				
Connecticut	131	696	222	32
Maine	18	33	3	9
Massachusetts	290	1,638	711	43
New Hampshire	13	82	8	10
Rhode Island	34	152	65	43
Vermont	42	108	21	19
Totals	528	2,709	1,030	38
Middle Atlantic				
New Jersey	190	783	465	59
New York	995	6,355	2,360	37
Pennsylvania	532	2,573	684	27
Totals	1,717	9,711	3,509	36
East North Central				
Illinois	366	1,916	704	37
Indiana	91	445	10	21
Michigan	276	1,809	499	28
Ohio	431	2,324	893	38
Wisconsin	129	584	151	26
Totals	1,293	7,078	2,257	32
West North Central				
Iowa	50	355	61	17
Kansas	53	302	76	25
Minnesota	129	1,254	178	14
Missouri	198	1,118	402	37
Nebraska	45	148	27	18
North Dakota	9	19	8	42
South Dakota	9	25	21	84
Totals	493	3,221	773	24
South Atlantic				
Delaware	21	46	33	72
District of Columbia	131	920	247	27
Florida	99	640	130	20
Georgia	119	656	112	17
Maryland	191	1,120	450	40
North Carolina	137	682	71	10
South Carolina	37	162	1	1
Virginia	128	674	148	22
West Virginia	53	140	112	80
Totals	916	5,040	1,304	26
East South Central				
Alabama	69	266	26	10
Kentucky	81	343	102	30
Mississippi	34	118	11	9
Tennessee	141	780	161	21
Totals	325	1,507	300	20
West South Central				
Arkansas	35	173	3	2
Louisiana	103	745	47	6
Oklahoma	84	268	24	10
Texas	278	1,501	189	13
Totals	500	2,687	263	10
Mountain				
Arizona	28	121	60	50
Colorado	112	676	119	18
Montana	1	4	4	100
New Mexico	14	26	1	4
Utah	63	307	24	8
Totals	218	1,134	208	18
Pacific				
California	516	3,214	107	3
Hawaii	27	133	39	29
Oregon	52	274	32	12
Washington	112	474	76	16
Totals	707	4,095	254	6
Territories and Possessions				
Canal Zone	8	33	1	3
Puerto Rico	51	256	36	14
Totals	59	289	37	13
Grand Totals	6,756	37,471	9,935	27

*Does not include American graduates of foreign medical schools, but does include 658 from Canada.

of 32,620 residencies were offered in hospitals. Another 166 were offered in institutions other than hospitals. The grand total, the largest yet, was 1053 more than the previous year. Residency was offered in 29 specialties and subspecialties, of which 24 were in hospital specialties. Six major specialties—surgery, internal medicine, psychiatry, pathology, pediatrics and obstetrics-gynecology—supplied 70 per cent of the available positions.

Nongovernmental, nonprofit hospitals constituted 63 per cent of the participating hospitals and offered 49 per cent of the positions. Nonfederal governmental hospitals constituted 24 per cent of the hospitals and offered 36 per cent of the positions. Federal hospitals constituted only 10 per cent of the total, but furnished 15 per cent of the positions.

Nongovernmental, nonprofit hospitals filled 86 per cent of their available positions; nonfederal governmental hospitals filled 90 per cent; federal hospitals 84 per cent, and proprietary hospitals 84 per cent. The grand total filled was 87 per cent of all available positions.

RESIDENCIES AND AFFILIATION

The 352 hospitals affiliated with medical schools were only 27 per cent of all hospitals approved for residency training, but they offered 54 per cent of the available positions. Although the affiliated hospitals were 4 per cent more successful than nonaffiliated hospitals in filling their available positions, it is quite clear, the authors of the report state, that university-affiliated hospitals do not provide enough positions to accommodate all the persons seeking residency training.

Residencies, both available and filled, are tabulated by census region and state in Table 2, page 18.

The authors also point out that "an 'average' stipend cannot be calculated for residencies, and data cannot be reported by hospitals because the stipends vary within the individual hospital in relation to the nature of the residency".

FOREIGN MEDICAL GRADUATES

During the 1960-61 academic year, foreign medical graduates made up 18 per cent (9935 out of 53,107) of all foreign citizens studying in the United States. These 9935 foreign medical graduates were 26 per cent of the total number of physicians serving internships or taking residency training in United States hospitals. This is the first time since 1954-55 that foreign interns made up less than one-third of the total interns—the result, as the authors point out, of the imposition of the July 1, 1960, deadline by the Educational Council for Foreign Medical Graduates. Table 3, page 19, shows, by census region and state, the number of foreign physicians in approved graduate training programs in the United States.

DIRECTORS OF MEDICAL EDUCATION

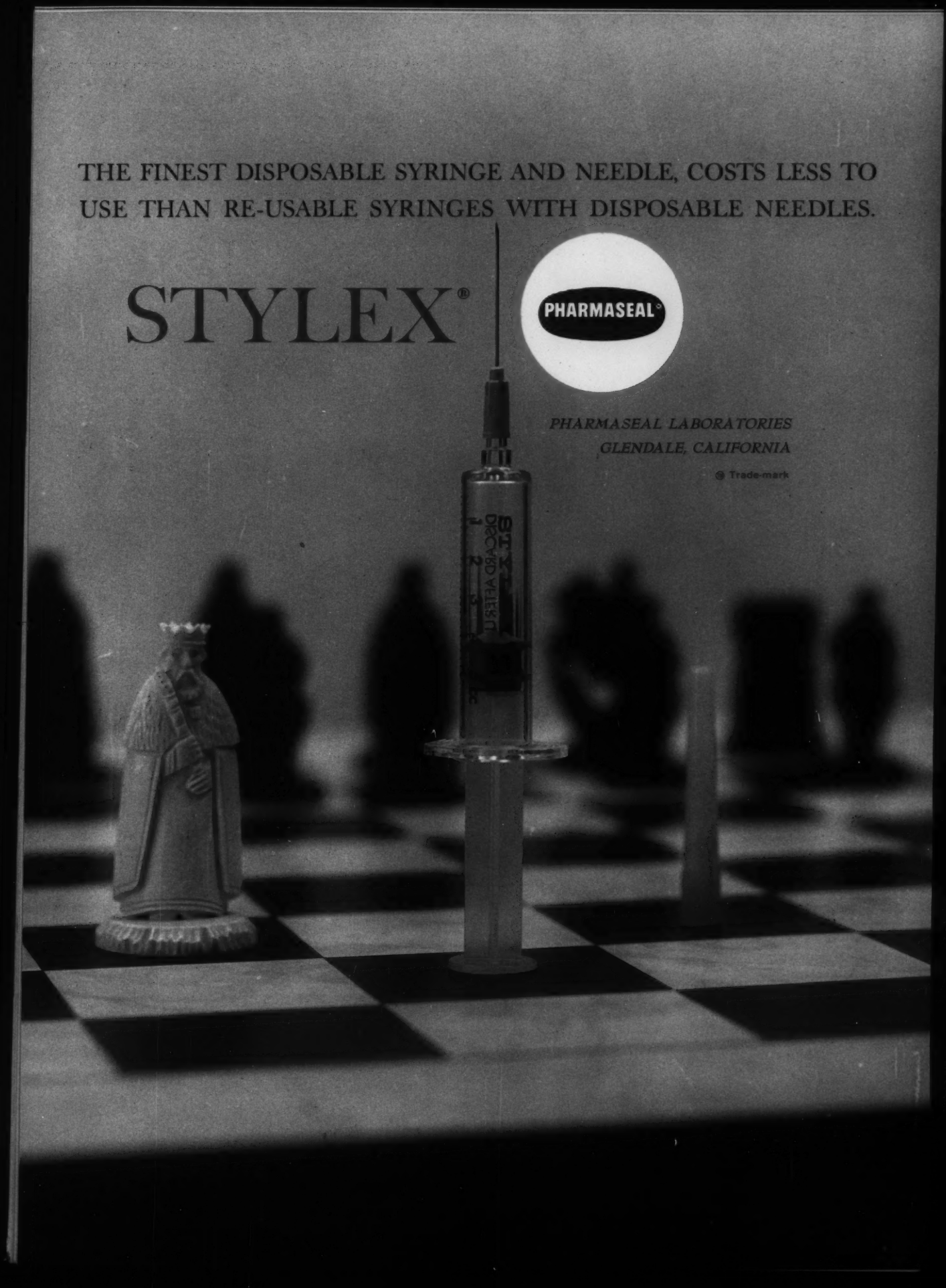
The questionnaire for this annual report included a question about full-time and part-time directors of medical education. Of the 850 hospitals replying, 357 had full-time directors and 493 had part-time directors.

Table 4, page 20, provides a picture of the status of graduate medical training in the United States since World War II. The authors state that the figures confirm an earlier prediction that the number of approved programs and available positions would level off. This, they expect, will continue in the future.

Table 4—Status of Internships and Residency Programs in the U.S.A.

	Internships							Residencies						
					Filled Federal Services							Filled Federal Services		
	Total Offered	Total Filled	Filled by U. S. Graduates	Filled by Foreign Graduates	V. A.	Other	Total Vacant	Total Offered	Total Filled	Filled by U. S. Graduates	Filled by Foreign Graduates	V. A.	Other	Total Vacant
1960	12,547	9,115	7,362	1,753	71	576	3,432	32,786	28,447	20,265	8,182	2,830	1,177	4,339
1959	12,580	10,253	7,708	2,545	55	584	2,327	31,733	27,590	20,619	6,912	2,650	1,456	4,143
1958	12,469	10,352	8,037	2,315	25	567	2,117	31,818	26,758	20,716	6,042	2,453	1,267	5,060
1957	12,325	10,198	8,119	2,079	48	566	2,127	30,595	24,976	19,433	5,543	2,403	1,049	5,619
1956	11,895	9,893	7,905	1,988	58	532	2,002	28,528	23,012	18,259	4,753	2,304	1,276	5,516
1955	11,616	9,603	7,744	1,859	55	495	2,013	26,516	21,425	17,251	4,174	2,353	624	5,091
1954	11,048	9,066	7,305	1,761	88	470	1,982	25,486	20,494	17,219	3,275	2,252	657	4,992
1953	10,542	8,275	6,488	1,787	88	433	2,267	23,630	18,619	14,817	3,802	2,072	639	5,011
1952	10,548	7,645	6,292	1,353	67	393	2,903	22,292	16,867	13,832	3,035	2,021	768	5,425
1951	10,044	7,866	6,750	1,116	71	472	2,178	20,645	15,851	13,618	2,233	2,120	761	4,794
1950	9,370	7,030	6,308	722	..	435	2,340	19,364	14,495	13,145	1,350	....	....	4,869
1949	9,124	7,313	....	†	..	...	1,811	18,669	17,490	....	†	....	....	1,179
1948	9,027	7,248	....	....	..	...	1,779	17,293	....	....	....	....	....	....
1947	8,683	6,902	....	....	..	...	1,781	15,172	....	....	....	....	....	....
1946	8,584	....	....	....	..	...	....	12,003	....	....	....	*	....	....
1945	8,429	....	....	....	..	...	....	8,930	....	....	....	....	....	....
WW II														
1941	8,182	....	....	....	..	...	....	5,256	....	....	....	....	....	....

*P.L. 293—Jan. 3, 1946—Authorizing Residency Programs in V.A.
†U.S. Information and Educational Exchange Act of 1948, effective July, 1949.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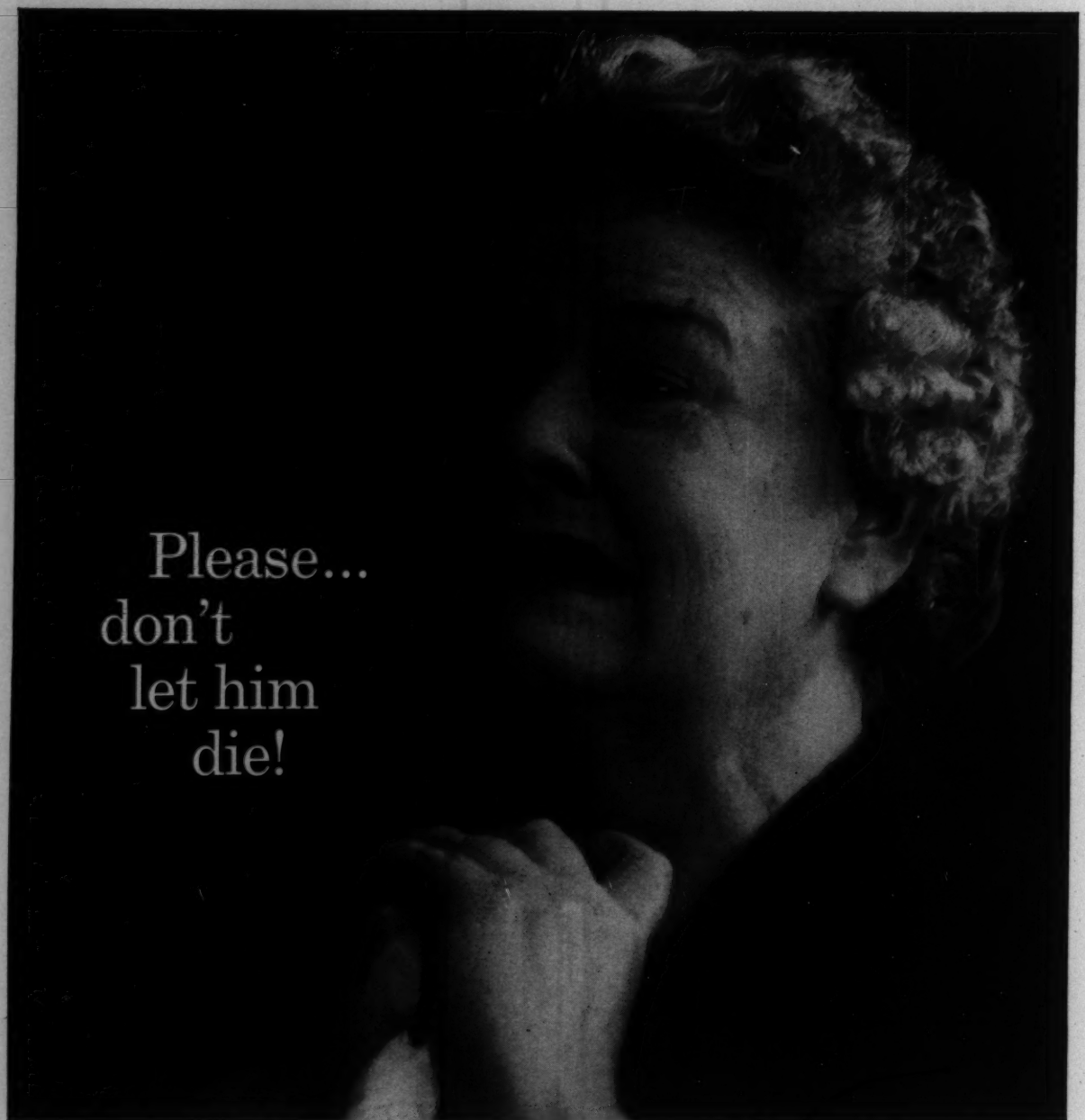
*If desired, epinephrine may be used in infiltration anesthesia for hemostasis.



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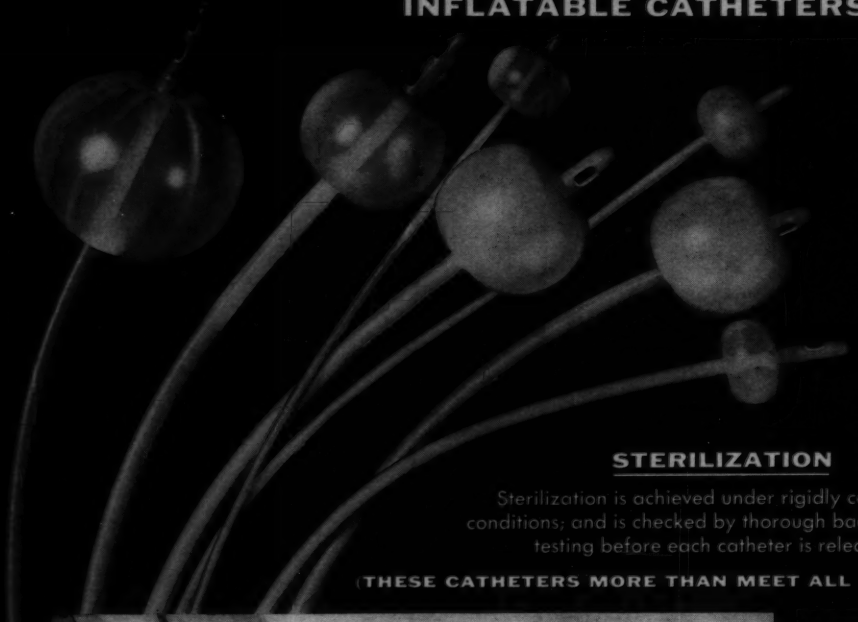

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Enforcing records completion

How can the administrator enforce the completing of medical records by physicians? Is there any means other than invoking the suspension provisions of the medical staff? We are very reluctant to resort to this in our hospital.

I am afraid that you are on the horns of a dilemma, for the only effective means of enforcing the completing of medical records by physicians is the threat or actual imposition of suspension of staff privileges, including the admitting of patients, until the delinquent records are completed.

I realize that this action on the part of the administration of your hospital may cause hardship to the hospital, but many other hospitals have taken this action with success. The possession of numerous uncompleted records and unrecorded radiological findings is detrimental to good patient care. One must consider the hazards in allowing such a practice to continue.

I do hope that you will be able to prevail upon attending physicians to complete their records, thus carrying out their responsibilities to the hospital and their patients.—J. R. ANDERSON, M.D.

Age limit for trustees

Does the American Hospital Association recommend establishing age limits for hospital trustees or members of governing boards?

No policy of the American Hospital Association has established any age limit for hospital trustees. Hospitals generally do not set any age limit on the service of hospital trustees, although some have established, for their own reasons, a cut-off age. Private industry, of course, does follow such a practice, probably because many directors are salaried officers of corporations.

I would suggest that as long as age does not interfere with a trustee's mental acuity, his age should not be a factor in determining his length of service.

There may be a danger, however, that younger persons may be precluded from participation on boards of trustees because older members will not retire. If a board recognizes this to be a fact, which could be to the detriment of the board's operation, it should either (1) include in the bylaws of the hospital a mandatory retirement age, or (2) limit by the same means the tenure of any board member to a given number of terms.—THOMAS E. CALLAHAN

Personnel management services

Does the American Hospital Association have a special membership division for hospital personnel directors? If so, what are the membership requirements?

The American Hospital Association does not have a special membership division specifically for hospital personnel directors. The AHA, however, does furnish a wide variety of services of value to personnel directors. Among them are the following:

1. The AHA annually conducts at least three institutes, on a national basis, for personnel directors, in addition to participating in the various programs of the state hospital association on this topic.

2. The Association has published several booklets on various aspects of personnel administration. These are listed in the publications catalogue of the AHA. One of these is a comprehensive manual on personnel administration in hospitals. This manual is currently undergoing revision and the revised edition will include sample forms for use in a hospital personnel office and a suggested personnel program audit.

3. The Association has a Committee on Personnel Administration which meets at regular intervals to prepare programs and materials to assist hospitals in the development of sound personnel practices.

4. The Asa S. Bacon library contains the largest collection of hospital literature in the world. From this collection, personnel directors of institutional members can obtain on loan a wide range of material on personnel management.

—WILLIAM S. SCHMIDT

Use of tabulating equipment

Please furnish information about installation of punched card processing equipment in hospitals for use in preparing and maintaining hospital diagnostic indexes. Please furnish also references in hospital literature to the use of such equipment.

In answer to your request, I am asking the library of the American Hospital Association to send you a collection of pertinent articles on this topic on a library loan.

You may be interested to know that the joint committee of the American Association of Medical Record Librarians and the American Hospital Association discussed this subject at some length in the course of its work of preparing a manual on medical record procedures (not yet published). The conclusions of the committee on this subject are reflected in the following paragraph taken from the most recent draft of the manual.

"Some hospitals maintain their indexes through the use of mechanical data processing equipment. It is important, however, to make a clear distinction between the use of the disease and operation index as a reference tool and the tabulating of data for the purpose of analysis. While hospitals having mechanical tabulating equipment may profitably use the equipment as a device for mechanical posting of the minimum information needed in the permanent reference index, by furnishing a list of patients' hospital numbers under each diagnostic and operative code number, it is inadvisable to use the punched cards themselves as index cards. The reason is obvious—excessive use of filing space for retention of one or more cards for each patient."

—HELEN D. MCGUIRE

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

raising funds?

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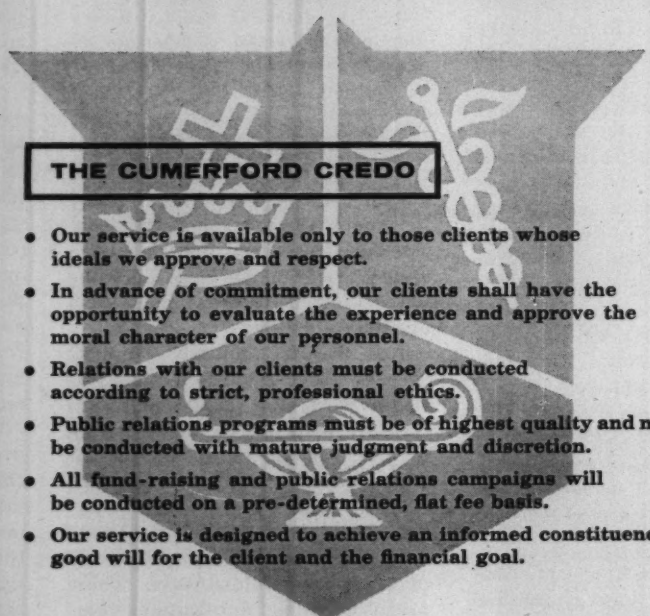

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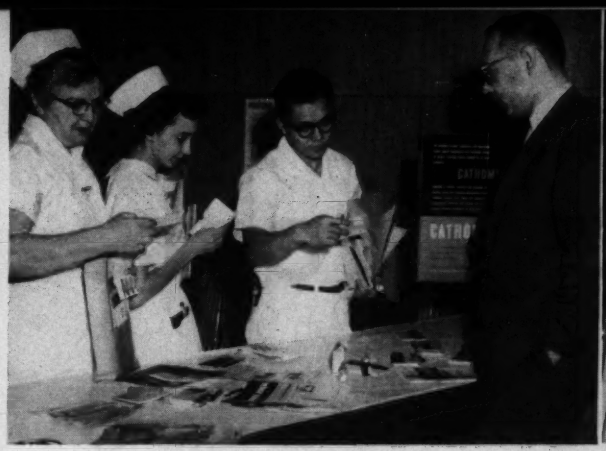


(LEFT) Representatives of 17 pharmaceutical companies answered questions and provided informative literature about their products for the staff nurses, student nurses and nursing instructors who attended this event. (RIGHT) Nurses learned about new drugs and how to administer them at a one-day "Drug Fair" at the Mount Sinai Hospital, Cleveland, conducted as a method of inservice training.

'Fair' brings nurses up to date on drugs

A one-day "Drug Fair" provided a means for the nursing staff and students at the Mount Sinai Hospital, Cleveland, to learn about new drugs and their administration.

How this fair was organized and how well it succeeded was related in an article in *Nursing Outlook* for August 1961 by Madeline E. Lester, assistant director of nursing service at this hospital.

The need for inservice training about new drugs was indicated by the staff nurses themselves in answer to a questionnaire. The hospital pharmacist cooperated in carrying out the program. He requested the representatives of the 17 pharmaceutical companies whose products were used most frequently at the hospital to provide exhibits and literature and to be present to answer questions about their products.

On the day of the "Drug Fair", exhibits were set up in the auditorium of the nurses' residence; each exhibit provided information about several drugs. The fair was open from 9 a.m. to 4:30 p.m., and staff nurses, student nurses and instructors in the school of nursing were given "time off" so that everyone was able to visit the fair for at least an hour. Coffee was served.

Advance publicity as well as the interest of the nurses in the subject helped to boost attendance figures. Under a system much like that followed at professional conventions, nurses went from one exhibit to another gathering literature about various drugs and asking questions of the representatives of the pharmaceutical companies. According to these men, the nurses wanted highly specific information about new drugs, such as various methods of administration and possible hazards. As each nurse left the exhibit, she was asked to submit written comments about the fair.

In addition to fulfilling its original purpose of providing information about new drugs for nurses, this "Drug Fair" reaped an unexpected benefit: instructors in the school of nursing "were able to establish personal contact with the representatives (of drug companies) for future teaching media". Also, the relations of the hospital with the drug companies were strengthened. All in all, this was a most successful event, according to Miss Lester, and one which the hospital plans to repeat. ■

Boy scouts learn first aid follow-up

Cooperation between the Health and Safety Committee of the Manhattan Council, Boy Scouts of America, and the surgical service of St. Luke's Hospital, New York, resulted in a course designed to interest teen-age boy scouts in a career in medicine. Staff physicians and surgeons acted as moderators for the eight-session course which was attended by 20 boy scouts.

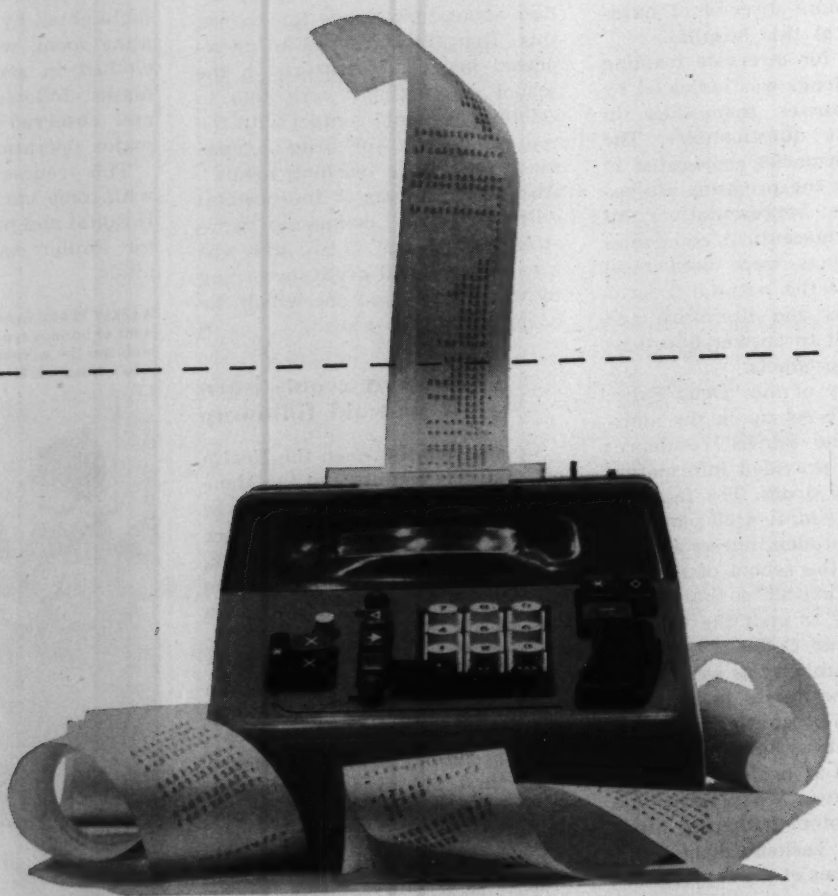
Using the boy scouts' knowledge about first aid as a springboard, each of seven lessons covered one of the seven major first aid problems: bleeding, shock, respiratory difficulties, fractures, burns, household poisonings and convulsions. The lessons usually began with a presentation of the first aid management by the boy scouts. Then a staff member discussed the medical and surgical care which followed first aid and explained the basic principles of anatomy and physiology involved. Patients observed in weekly ward rounds illustrated hospital care of various types of cases.

Last session of the course was highlighted by a visit to the operating room, where the boys were clothed in scrub suits, caps and masks, followed sterile technique and observed preparations for a major operation.

This course may be repeated with some variations at St. Luke's Hospital and may serve as a model for similar courses at other hospitals. ■

WEEKLY WARD rounds illustrated the management of various types of medical and surgical problems in a course for boy scouts at St. Luke's Hospital, New York.

Hospital costs rise and rise



The inflationary spiral steadily pushes hospital costs up—up—up. Hospitals help defeat the inflationary spiral by reducing costs of labor and equipment demanded by older, more time-consuming injection systems. By utilizing the TUBEX Closed Injection System, Wyeth, professional nurses are then used for nursing only and accounting is more efficient. Most important, costs can be billed accurately and justifiably to patients. As labor costs and equipment costs continue to rise, the economy of the truly modern injection system—TUBEX—inevitably will be realized by more and more hospital administrators.

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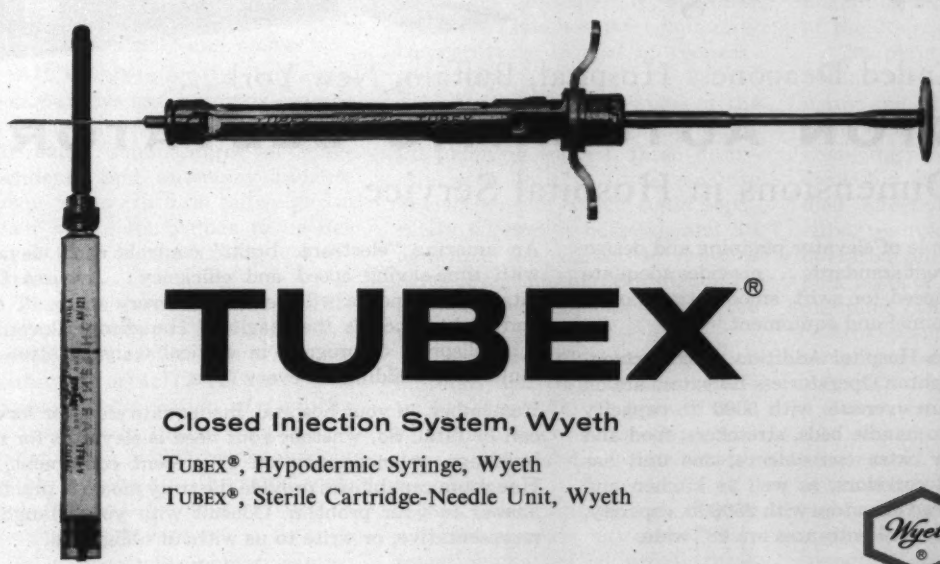

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HOSPITALS
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editorial notes

—autonomy and hospital planning

AREA-WIDE hospital planning, like any other coordinated group activity, like democracy itself, requires from the participating individuals and organizations the voluntary relinquishment in some degree of the right to unilateral action for the benefit of all concerned. The main reasons for a hospital's relinquishment of complete independence and autonomy are better distribution of patient-care facilities and services and more effective utilization of community resources, such as personnel and money.

All too frequently, however, communities and hospitals are unwilling to, and therefore do not, surrender some degree of independence and autonomy because some other factors outweigh in their views the values to be derived from joint planning and action.

The consequences of this unwillingness include (1) inadequate distribution of facilities and services within an area; (2) needless and expensive duplication of facilities and services; (3) a standard of patient care which varies widely within hospitals in the same area, and (4) an uneconomical use of community resources.

In a large metropolitan center, there are 6.9 beds per 1000 population north of a main traffic artery; south of it are 2.8 beds per 1000 population. Here is a situation pleading for the benefits which joint planning might confer. Since hospitals, planning council and city officials all recognize the need in the instance, perhaps corrective action will soon be taken.

In a rural area, two brand new hospitals, built with Hill-Burton funds and built to serve the only two communities nearby, are within 20 minutes drive of each other. Although one is somewhat larger than the other, they offer practically the same services to a hospital community which would have received adequate care from either one alone. Consequently, they now serve the same hospital community competitively instead of cooperatively.

In another area, in spite of the warning and appeals of the hospital planning council, three hospitals were built in three separate towns, none of which could separately support a hospital, and all of which are within 40 minutes drive of one another. Consequently, the average occupancy rate of the three is 10 per cent.

Coordinated planning, in which hospitals and communities voluntarily participate, can prevent such situations. Such action may, and does, transcend governmental boundaries.

Two towns situated not only in different counties but also in different states leaped across these boundaries and cooperated in the building of one hospital to serve the population of both municipalities. Here is an example of thoughtful planning and wise action, which will benefit this hospital community by avoiding unnecessary duplication of facilities and services and by making economical use of community resources including personnel as well as money and materials.

In another state, three cities joined to form a hospital district to provide hospital services in an area which was designated as the area with the second highest need for a hospital in the entire state. When civic and hospital leaders made clear what joint planning and action could do to meet the need, residents of the three cities voted 15 to 1 in favor of the necessary bond issue to construct the hospital. In addition to having modern equipment and up-to-date features, the hospital's present utility and service installations are capable of handling double the present patient load.

Joint planning can be done effectively and well—if the parties concerned are willing to engage in it. If they are, the question then is: How shall the planning be done?

Rosson L. Cardwell and Karl S. Klicka, M.D., write in their article beginning on page 43 of this issue of the Journal:

"The plain fact is that in metropolitan areas, where hospitals are many and diverse, and where the population is growing, shifting and changing, hospital planning has become too complicated to be handled effectively on the basis of either individual planning or cooperative planning. . . . These complex tasks of metropolitan hospital planning can be performed by a central planning agency with a competent staff of planning specialists."

Obviously, these authors imply that in such areas, hospital planning cannot be done by means of a less highly organized and less highly specialized instrument than a metropolitan hospital planning council. Hospitals in metropolitan areas should certainly support the formation of such an instrument, where it is lacking, and where it is present, should wholeheartedly support its activities.

BED SUPPLY AND HOSPITAL UTILIZATION: *a natural*

According to the author, a sudden increase in the supply of hospital beds in one county in an eastern state resulted in a prompt rise in the hospital admission rate and the average length-of-stay for most diagnoses. He discusses a study which offers evidence that, with widespread health care insurance, the bed supply determines the hospital utilization rate, through its influence on the practices of the physician.

THE STEADY rise in hospital costs has stimulated a wider-ranging search for culprits, among which the hospital utilization rate has been one of the most suspect. Numerous aspects of the behavior of American patients, physicians and hospitals have been indicted for contributing to overutilization.[1] Yet, little has been done to cope with the factor which, probably more than any other, determines the rate of utilization of hospital beds in any community, state, or nation.

Elsewhere we have contended that the supply of hospital beds in a community or state is the major determinant of the hospital utilization rate.[2] This has been based on experience in several countries, statistical correlation studies for 48 states of the United States and for the 56 upstate counties of New York State, and also on everyday observations of medical practice. Studies in Massachusetts have confirmed this hypothesis[3] as have investigations in England.[4] We have even been accused of discovering a new scientific "law"[5] and of concocting, what is worse, a hospital modification of Parkinson's law about work filling the time available for its completion.[6]

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This article is adapted from a presentation given at the annual meeting of the New York State Public Health Association, Rochester, N.Y., June 5, 1961.

The author wishes to acknowledge the assistance of Dr. Phoebe T. Goggin, Mrs. Betty Matheney and Mrs. Elsa Windh for their assistance with the statistical work involved in this study.

SUPPLY SETS RATE

The limitation that the hospital bed supply sets on the maximum utilization rate is obvious enough, and no one seems to question it. Hospital days can hardly be provided at a rate higher than the beds available. The contrary limitation,

experiment

by MILTON I. ROEMER, M.D.

however, is sometimes questioned —namely, the notion that under conditions of insurance or other prepaid support, the supply of beds tends to set a minimum utilization rate as well. It is claimed by some that hospital beds are usually built in relation to need so that the bed supply is a result rather than a cause of the utilization rate. Others point to the empty beds in most hospitals on an average day—the vacancy level[7]—suggesting that there are, indeed, facilities that are not being used.

Undoubtedly bottlenecks in hospital management or inadequacies of insurance coverage yield less-than-maximum occupancy levels, even while unmet needs for hospital care can readily be demonstrated (witness only the patients in substandard nursing homes who belong in general hospitals). The critical fact, however, is that occupancy level in the United States is not highest where the bed supply is lowest—as one would expect if medical need were the real determinant of the utilization rate. The percentage of vacant beds in the hospitals of a state is approximately the same regardless of the ratio of beds to population. It tends to be greatest in states with lower levels of insurance coverage, rather than higher supplies of beds. The need for hospital beds, in other words, is full of social and subjective determinants, and the level at which need is recognized is heavily influenced by the supply of beds available for its satisfaction.

TESTING A HYPOTHESIS

To test the hypothesis that the supply of beds in a community is a major influence on the hospital utilization rate, one can visualize an ideal experimental situation. The community should be one that has had a satisfactory level of medical care for some time. It should be a place where the public has had a relatively high consciousness of health needs, and the resources for medical services, in personnel and facilities, have been good. Then, rather abruptly the supply of hospital beds should be greatly increased. Other factors like the local population, the illness level, the supply of personnel and the capacities of science should remain about constant or change very little. But the bed supply should be suddenly increased by a degree that could yield a clear and perceptible effect. The question is: what would happen to the hospital utilization rate under such circumstances?

AN EXPERIMENTAL SITUATION

Precisely such an experimental situation was presented in an upstate New York county during the period 1957 to 1959. In 1957, this county of 53,614 population* was served by a general hospital of 139 beds. The building was old and poorly planned; yet, it seemed to have met local needs, as they were recognized, for many years. Although there was pressure on the hospital's service facilities, the beds were not excessively crowded, with an occupancy level for the year of 78 per cent. According to state governmental standards, the space in the building should have accommodated only 81 beds, but these plus the additional 58 beds set up managed to cope with admissions. Physicians report that no one was ever turned away for lack of a bed. A small proprietary general hospital of 12 beds was also operating in the county at this time, so that the over-all bed-population ratio was 2.81 per 1000 persons.

In 1958, a large new building was acquired. Because it was a former tuberculosis hospital converted to general hospital use, it was made ready while the old building was still in use. Then on "D-day", the move occurred. Overnight, an institution of 221 approved beds was acquired—more than double the old approved 81-bed capacity. In fact, 197 beds were set up in the new building, which, by the most conservative calculation, still represented a sudden expansion of actual bed complement by 42 per cent. (If only the beds meeting approved standards are considered, it is apparent that the rise in bed supply of the hospital over the two-year period was theoretically 140 per cent.) The new building was more spacious and more technically adequate in all the service facilities as well. The 12-bed proprietary hospital was still in operation throughout 1959, and the county population had risen slightly to 54,976. Thus, the bed-population ratio in the county for 1959 had risen to 3.8 per 1000 persons. With this great expansion of bed capacity, the occupancy level of the hospital fell somewhat to 70 per cent, while the daily census rose from 108 to 137 patients.

UTILIZATION RATE JUMPS

Under these circumstances, what happened to the hospital utilization rate between 1957 and 1959? Briefly, it rose sharply. The rise occurred in number of admissions as well as in average length-of-stay. By both these basic indexes,

*Excluding 10,559 university students who were served by a special infirmary.

Table 1—Hospital utilization in an upstate New York general hospital: number of admissions, average length-of-stay and total patient days during 1957, 1959 and 1960.

	1957	1958	1959	1960
Number of admissions*	5,787	Bed expansion	6,471	6,765
Average length-of-stay*	6.9		7.3	7.5
Total patient days*	39,574		47,538	50,646

*Including maternity cases but excluding newborns.

it continued to rise further in 1960. The fundamental data are given in Table 1, p. 38.

It is apparent that between 1957 and 1959, the number of patient days of care provided in the study hospital rose by 20 per cent. By the end of 1960 when patterns of use of the larger hospital had become better established, patient days had risen by 28 per cent. In this period, the population of the county increased very little. With 1957 as the base year, it rose by 2.5 per cent in 1959 and 3.7 per cent in 1960. The geographic area served by the hospital over these years remained essentially unchanged. One can say, therefore, that the rate of hospital admissions and patient days climbed substantially as soon as the bed capacity was expanded. Calculated as a rate (with the population of the study county constituting the hospital service area for the two years), the utilization rate rose from 738 to 905 days per 1000 persons per year between 1957 and 1959.

The heavy influence of bed supply on hospital utilization under insurance support is seen even more strikingly by examining the figures for Blue Cross subscribers separately. Between 1957 and 1959, the Blue Cross patient days in the study hospital increased from 9703 to 13,381, or by 38 per cent. The closeness of this to the 42 per cent rise in bed capacity is worth noting. During the same period, Blue Cross utilization in five nearby hospitals, where bed supply was nearly constant, rose only from 80,697 to 83,620 patient days, or by 3.6 per cent.

Perhaps the most significant figures in Table 1 are those on average length-of-stay. Insofar as purely technical considerations (for example, the increased effectiveness of drugs or principles of early patient mobilization after surgery) have an impact on medical practice, average durations of hospital stay have been decreasing in the United States for some years. Between 1946 and 1958, for all nonfederal, short-term general (and other special) hospitals, they declined steadily from 9.1 to 7.6 days. For some reason (perhaps the impact of more long-stay geriatric cases), a small rise of average length-of-stay to 7.8 days occurred in 1959 among all these hospitals in the nation as a whole. For short-term general hospitals in the country of the same size as the study hospital (100-199 beds), the average length-of-stay in 1957 was 6.9 days, and in 1959 it was 7.1 days. The rise of average length-of-stay in the study hospital from 6.9 to 7.3 days between these years is significantly greater. It continued to rise to 7.5 days in 1960, while it fell again nationally in that year to 6.9 days. It must be emphasized that this was combined with a rise in the rate of admissions as well. This usually means acceptance of cases of lesser rather than greater average severity.

But what exactly happened to the practice of medicine and the provision of medical care in the study county over this period? Were there suddenly more sick people? Was there a sudden increase in the volume of health services needed in 1959 and therefore provided? Objective morbidity data are not available, but the county health officer reports no significant increases in illness. Indeed, the Asian influenza epidemic occurring in 1957 may have actually made that year one of higher morbidity than 1959. Insofar as the crude death rate is an index

AUGUST MOST POPULAR BIRTH MONTH

More births occur in August than in any other month, according to a survey by the Health Insurance Institute. Rooms in hospital maternity departments are in greatest demand during this month, with September and October coming in second and third. The demand tapers off in February, April, May and June. During August 1961, at least 400,000 babies were born in the United States. Of these total births, 96 per cent took place in hospitals, compared to 56 per cent in 1940 and 37 per cent in 1935. Meanwhile, the total number of births continues to rise, with the early months of this year showing a 3 per cent increase over last year.

of medical need, it actually declined from 8.7 to 8.6 per 1000 population in the study county over the two-year period.

As for medical resources in the county, there was a slight increase in the number of physicians between 1957 and 1959. The medical staff of the hospital increased from 59 to 64 active members. This was far less than the rise in bed supply, however, so that the new hospital provided 3.05 beds per physician on its active staff, compared with 2.36 beds in the old hospital.

ANALYSIS OF RECORDS

An attempt was made to determine exactly how physicians responded to this sizable expansion of bed facilities by analysis of patient records. All the diagnostic case cards in the hospital record room were analyzed for the two years of study. Data on the number of admissions and length-of-stay for each diagnosis in 1957 and 1959 were tabulated. Some 1028 diagnostic categories were recorded, these being based on the *Standard Nomenclature* of the American Medical Association. We translated these into 53 principal diagnostic entities and 15 major diagnostic groupings, derived from the *International Statistical Classification of Disease, Injuries, and Causes of Death.** As one author recently pointed out, this task of classifying hospital statistics is beset with difficulties.[8] One of the most serious of these is the tendency of most hospitals—the study hospital included—to record all diagnoses on the summarizing case cards (not distinguishing primary from secondary ones), so that there are usually far more discharge diagnoses than patients.

These facts on our methodology are mentioned to clarify our procedures, but the findings of this analysis of diagnoses can only be partly reported at this time. An arithmetical check disclosed that several hundred hospital case cards from 1957 seemed to have been lost, rendering our findings on rates of admission unreliable. The findings on average length-of-stay, however, would not be greatly distorted by this problem, since several thousand individual diagnoses were still available for analysis—3375 for 1957 and 8093 for 1959. The basic findings are presented in Table 2, p. 39.

*International Documents Press (Columbia University Press), New York, 1948.

Table 2—Hospital utilization by major diagnostic groupings: length-of-stay for cases admitted to the study hospital, 1957 and 1959.

Major Diagnostic Grouping	1957	1959
Infectious and Parasitic Diseases	7.0	7.8
Allergic, endocrine, metabolic and nutritional diseases	7.7	10.9
Diseases of the blood and blood-forming organs	6.5	12.4
Mental, psychoneurotic and personality disorders	14.7	5.9
Diseases of the nervous system and sense organs	9.8	13.7
Diseases of the circulatory system	15.5	18.2
Diseases of the respiratory system	7.7	7.7
Diseases of the digestive system	9.8	10.6
Diseases of the genitourinary system	7.3	9.1
Complications of pregnancy, childbirth and the puerperium*	3.3	4.1
Diseases of the skin and cellular tissue	7.9	15.9
Diseases of the bones and organs of movement	10.9	12.5
Congenital malformations	12.8	5.2
Symptoms, senility and ill-defined conditions	10.8	13.8
Accidents, poisoning and violence	7.2	8.1

*Normal deliveries tabulated in Table 6, p. 42.

The basic findings are presented in Table 2, p. 39.

It is evident that for 12 of the 15 major diagnostic groupings, the average length-of-stay increased between 1957 and 1959; for one it remained the same, and for only two did it decline. Considering the 53 specific diagnoses, there were 40 in which the average length-of-stay rose, and 13 in which it declined. These are listed in Table 3, p. 40.

PATIENTS KEPT LONGER

Whatever may have happened to the rate of admission by diagnosis, a rise in the average length-of-stay—assuming no objective evidence of heightened morbidity—means that patients were being kept hospitalized, on the average, for longer periods. A reduction in average stay, on the other hand, should not be interpreted to mean that the patients with these diagnoses were generally kept hospitalized a shorter period of time. It is altogether possible that for these particular diagnoses the admission rate in 1959 was higher, meaning acceptance of many mild cases requiring only very short stays; the more serious cases may have been hospitalized for as long or longer than in 1957. This speculation, however, can only be verified when complete data are available for study. Until then one can say that an increased bed supply was associated with an increased average length-of-stay in the large majority of diagnoses. Certain concentrations of this effect are reflected in Table 2. The over-all rate of admission and the aggregate days of care provided to the population was also greatly increased, as reflected in Table 1.

QUESTIONS RAISED

Having reviewed these findings, one may raise some queries. Is it possible, perhaps, that the rise in rate of admissions to the study hospital was due simply to attraction of patients from afar who might otherwise have gone to "competing hospitals? In other words, was the population base served by the study hospital rather suddenly widened with its in-

Table 3—Specific diagnoses showing an increase or a decrease in average length-of-stay between 1957 and 1959.

Increase	Decrease
Infectious diseases (except TB)	Mental diseases
Tuberculosis	Cardiac disease
Allergies	Respiratory diseases of circulatory origin
Deficiency diseases	
Diseases of metabolism	Diseases of the pancreas
Diseases of the thyroid gland	Diseases of the liver and gall bladder
Diseases of the lymphatic system	Diseases of the stomach and esophagus
Anemias	
Diseases of the spinal cord and nerves	Diseases of the colon
Eye disorders	
Diseases of the brain and meninges	Diseases of the kidney
Diseases of the ear	Diseases of the ureter
	Diseases of the urethra
Cardiac arrhythmias	Diseases of the vulva and vagina
Other diseases of the vascular system	
Diseases of the pharynx	Diseases or injuries of bone
Diseases of the sinuses, larynx and nose	Congenital deformities
Tumors of the respiratory system	
Pneumonias	
Diseases of the bronchi, lungs and pleura	
Diseases of the rectum and anus	
Diseases of the mouth, teeth and gums	
Diseases of the intestines (except colon)	
Diseases of the appendix	
Hernias	
Diseases of the male reproductive organs	
Diseases of the bladder	
Diseases of the cervix	
Diseases of the uterus fundi	
Diseases of the ovaries and tubes	
Complications of pregnancy	
Diseases of the skin	
Diseases of the female breast	
Diseases of the joints	
Diseases of the muscles and ligaments	
Postoperative complications	
Other tumors in the body (benign and malignant)	
All other conditions (ill defined)	
Poisoning	
Trauma	
Burns	

creased capacity, so that the rate of admissions (the number of cases divided by the number of persons in the population served) did not really rise?

To answer this question, data were obtained from the Blue Cross Plan serving the entire region. The findings are shown in Table 4, p. 41, for the five nearest hospitals from which one might have expected patients to have been drawn. It is apparent that in three of the five nearby hospitals, there was also an increase in the total volume of patient days between 1957 and 1959. Although there was a decrease in two of them, the net change for all five was not a decrease but an increase of 2768 patient days. Since this was beyond the rise from 1957 to 1959 of 7964 patient days of care provided in the study hospital, it can hardly be said that the latter rise was because of a withdrawal of patients from the other nearby hospitals.

IS DISTANCE A FACTOR?

Another way of looking at this question is in terms of the places of residence of the patients actually entering the study hospital in 1957 and 1959. Information was not available for 1957, but the essential data for 1956 compared with 1959 are presented in Table 5, p. 41. Contrary to the supposition of the previous query, there was certainly no rise in the proportion of patients coming from distant points. In fact, just the opposite occurred. Between 1956 and 1959, the major rise in the source of patients came from the local community. There is a small rise in the proportion of patients coming from other towns in the state, which was more than offset by a relative decline in the proportion coming from other towns in the local county, rural places in this county and other states.

MEDICAL POLICY CHANGE

It would seem to follow, therefore, that the great rise in utilization of the study hospital, associated with the increase in its bed supply by 42 per cent, was because of the changes this caused in the medical policies of the local physicians. There was simply an increased tendency to hospitalize patients in the given population, without any evidence of a corresponding increase in the incidence of illness. Furthermore, whatever may have happened to the objective occurrence of illness, there can be no question about medical policies once admitted; for 40 of the 53 diagnoses, patients were kept hospitalized, on the average, for longer periods of time.

Although these changes in medical policy were made possible and encouraged by the absolute and relative increase in the supply of beds, this was not the only change in the hospital to account for the difference in utilization. There were other modifications in the physical plant as well. The new hospital building was superior in all technical aspects. The floor space per bed was greater, and the furnishings were better. The laboratory and x-ray facilities were modernized so that cases could get a better diagnostic work-up. Between 1957 and 1959, the number of inpatient x-ray examinations increased from 2485 to 3733, or a rise from 0.43 to 0.58 x-ray studies per admission. Every clinical department was enlarged, particularly the pediatric ward. There were more operating rooms and better surgical equipment in them. The kitchen and laundry were greatly improved. More and brighter waiting rooms were provided for visitors.

STAFF EXPANSION NOTED

Along with the physical improvements was an expansion of staffing. The administrator reports a rise of nursing service from approximately 4.5 hours per patient day in 1957 to 5.5 hours in 1959. Improved equipment caused a reduction in the kitchen and laundry staffs, but a slight increase in housekeeping and maintenance personnel. The number of medical residents in training increased between 1957 and 1959 so that attending physicians were aided in doing a more thorough work-up of cases.

It is small wonder, therefore, that, once admitted, patients were kept in the new hospital for longer periods of time. On questioning a number of members of the hospital's medical staff, one learned that, "we used to send minor accident cases home from the old hospital after a brief check-up; now we keep them overnight to be sure everything is all right." "A patient admitted for a cardiac diagnosis is now kept for the treatment of other associated conditions." "We now admit mental patients from the local clinic and watch them a few days, instead of putting them on drugs and sending them right home." "There are lots more medical consultations now, and that takes time in the hospital."

The increase of beds in the hospital by 42 per cent was not the same in all departments. In pediatrics, it was an increase from 10 to 20 beds, or 100 per cent. In medicine and surgery, it was an increase from 97 to 140 beds, or 44 per cent. In obstetrics, the rise was from 32 to 37 beds, or only 16 per cent. It may be observed that where nature, rather than medical judgment, dictates the bed need, the percentage increase in bed allotments was least.[9]

Aside from these changes in the physical structure and staffing of the hospital between 1957 and 1959, there were no changes in formal medical staff policy on admission and discharge of patients. There has been no medical staff committee to review the soundness of admissions or the justifiability of a patient's occupancy of a bed beyond a certain duration. Even in the relatively crowded conditions of 1957, no such formal procedure existed. There were informal understandings among the physicians on the use of beds, and when a place was needed convalescing patients were discharged a day or two sooner to make room for the new case. The same informal system prevailed in 1959, although it seldom had to be invoked. With the reduced pressure for beds, physicians state that the *esprit de corps* of the hospital staff is far better than ever before.

All these findings would seem to add up to the simple conclusion that the number and type of hospital beds materially influenced the practice of medicine in the study hospital. They substantially determined the hospital utilization rate of the local population.

OBSTETRICS: SPECIAL CASE

A special word should be said about normal obstetrics, which is perhaps the most "nature-gener-

Table 4—Utilization of hospitals near the study community: volume of patient days in five nearby general hospitals, 1957 and 1959.

Hospital	1957	1959	Net change
A	58,355	62,549	+4,194
B	68,039	66,790	—1,249
C	36,467	37,876	+1,409
D	90,277	90,525	+ 248
E	84,697	82,863	—1,834
All hospitals	337,835	340,603	+2,768

Table 5—Places of residence of patients served: percentage distribution of admissions to the study hospital, 1956 and 1959.

Place of residence	Percentage of patients	
	1956	1959
Local city	55.9	57.4
Other towns in the county	24.1	23.2
Rural places in the county	8.9	8.1
Other towns in the state	10.2	10.7
Other states	0.8	0.7
All places	100.0	100.0

ated" as aginst "physician-generated" cause for hospital admission. With medical judgment having little if any influence over admission for this diagnosis, what was the experience? The custom of the study hospital's record department is to maintain data on obstetrical admissions and newborn length-of-stay, but the latter may be accepted as roughly parallel to the experience of the mothers in the postpartum period. By this measure, in contrast to the findings for all other diagnostic categories as a whole, there was a decline between 1957 and 1959 of both admissions and average length-of-stay for normal maternity cases. The data are shown in Table 6, p. 42. What could be the explanation of this exceptional finding?

First of all, as shown in Table 6, there was an actual decline in the crude natural birth rate in the county, from 23.2 per 1000 population to 22.9 between 1957 and 1959. Secondly, there is a special feature of the Blue Cross hospitalization plan covering this county which is relevant. In contrast to other admission diagnoses, maternity admissions are not financed completely by the insurance plan. Instead, a flat $80 indemnification was paid in both 1957 and 1959. In this interval, however, the per diem cost of hospital care rose substantially—approximately 25 per cent. The noninsured balance payable by the patient, therefore, rose substantially, which may have been expected to exert a deterrent effect on length-of-stay, selective for this diagnosis and not others. Associated with these influences was the fact that the capacity of the hospital's obstetrical department increased over the study period by only 16 per cent, in contrast to an expansion in other clinical departments by 50 per cent (107 to 160 beds). All these circumstances, in turn, were reinforced by a long-term trend in obstetrical practice toward shorter lengths-of-stay to reduce the liability of pulmonary embolism and other complications of childbirth. All in all, the exceptional finding in normal obstetrical admissions only serves to strengthen the interpretation of our predominant findings as due to the influence of bed supply upon medical decisions and, hence, hospital utilization. Indeed, it is clear that if the hospital utilization data were considered exclusive of normal obstetrics, the general rise in both admission rate and average length-of-stay, associated with the expanded bed capacity, would be even more striking.

Table 6—Maternity hospitalization: birth rate in the study county, number of childbirths in the study hospital and newborn hospital utilization, 1957 and 1959.

Maternity Item	1957	1959
Birth rate (per 1000 pop.)	23.2	22.9
Number of obstetrical admissions	1535	1483
Number of live births	1449	1423
Average length-of-stay of newborns (days)	4.8	4.5
Total days of newborn care	6935	6461

NO ABUSE NOTED

All this is not to imply that the period of higher bed supply was associated with abuse of the hospital, for it is quite as reasonable to say that the earlier period was one of deprivation of hospital service. We simply do not know what an optimal level of hospital utilization was in the United States in 1959 or is in 1961. We do know that this fairly prosperous study community "got along" for many years with a much lower bed-population ratio than it suddenly acquired in 1958, and when the supply of beds was increased, the new beds were quickly brought into use.

This study does suggest, however, the central importance of the supply of beds in determining the hospital utilization rate for which a community, a region, a state, or a nation must pay. It does suggest that if there is to be any effective control over the utilization rate, it should rest first of all on some sort of control over the supply of beds that are built and put into use. No state in the nation now exercises such control.

POSSIBLE CONTROL METHODS

Some have spoken of the possibility of a "franchise" over hospital construction.[10] Others have spoken of assigning authority to regional councils for approval of new bed construction.[11] Whatever method is followed, some over-all authority would seem to be necessary. If such is established, serious research would have to be launched to determine the true need for hospital beds at a given time and place, according to some objective criteria of health status and social circumstance.

The likelihood is that such determination would result not in a reduction but in an elevation of the customary standard of 4.5 general beds per 1000 population in the United States today. Whatever the level should be, it would permit the community, state, or nation to finance hospital service at a level which it is prepared to finance—without anxieties and diatribes about overuse, mismanagement and waste. ■

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THE CASE FOR COORDINATED HOSPITAL PLANNING

Part 1—The need

by ROSSON L. CARDWELL and

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Although the need for area-wide hospital planning is now widely recognized, the authors state, the process of planning itself is not yet well understood. In the first part of a three-part article, the authors clarify the concept of long-range planning for hospitals and discuss the relative merits of individual planning, cooperative planning and coordinated planning.

In Part 2, to appear in the November 16 issue, the authors will discuss the possible disadvantages of coordinated planning from the individual hospital's point of view as well as the advantages of this type of planning, both to hospitals and the community.

In Part 3, which will appear in the December 1 issue, the authors will suggest ways in which hospital interests and physician interests may be brought into harmony with community requirements in developing a successful program of coordinated hospital planning.

ALMOST everyone these days is aware of the need for planning. The rapid pace of our world and the increasing complexity of its problems make it easy to recognize the importance of forward vision and cooperative action. But recognition of the need for planning does not automatically create understanding of the planning process, nor does it eliminate the conflicts that frequently arise when attempts are made to bring independent units together into a total coordinated effort.

This state of affairs is well illustrated in the hospital field. Evidences of heightened hospital interest in planning are apparent everywhere. Twenty years ago the Hospital Council of Greater New York was the only metropolitan hospital planning agency in the country; today agencies with broad hospital planning functions have been established in four major cities;* agencies with partial planning functions are operating in 8 more cities,** and still other groups are in process of formation.[1] Since 1946, when Congress passed the Hill-Burton Act, state-wide planning agencies have been established in each of the states to carry out the federal program of subsidies for hospital construction on the basis of measured needs and coordinated planning. Activities of the American Hospital Association have also reflected a mounting interest in metropolitan hospital planning, culminating this past year in its joint sponsorship with the U.S. Public Health Service of a special study committee on area-wide planning for hospitals and related health facilities.[1]

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PLANNING PROCESS MISUNDERSTOOD

Yet despite these evidences of a growing emphasis on broad planning for hospital care, other evidence indicates that the process of planning is not generally well understood and that hospitals themselves are not sure where or how they fit into the total planning picture. A 1958 research study of long-range planning in 895 nonfederal general and short-term special hospitals done by a management consulting firm[2] showed that, at most, only approximately 50 per cent of metropolitan area hospitals and 31 per cent of hospitals outside metropolitan areas had made plans for their own future development. Relatively few of the hospitals reporting in this study had made plans extending beyond five years into the future and very few reported any participation in area-wide planning efforts. Results of this study also suggest that individual hospitals vary widely in the factors they consider and the way they consider them when making planning decisions. The total picture that emerges is one of a highly fragmented and haphazard planning effort, with each hospital proceeding in its own direction and at its own pace, with little awareness of how its plans (or lack of plans) may affect other hospitals or its community as a whole.

Given the current high interest in area-wide hospital planning and the relatively low stage of its current development, an exploration of some of the major problems and issues involved seems in order. Perhaps the best place to start is

with the basic concept of long-range planning.

In essence, long-range planning is a process for setting goals and for determining the steps necessary to achieve them. Or, looked at in another way, it is a tool by which an institution or a community can establish some degree of control over its own future.

MAJOR DECISION AREAS

For institutions and communities alike, long-range planning offers an organized way of finding answers to two important questions: Where do we want to be at the end of 5, 10, 15 or 20 years? How is the best way for us to get there by then? To qualify as genuine long-range planning, rather than casual blue-skying, the look into the future should be well organized and should cover each of nine major decision areas: (1) community need; (2) hospital objectives; (3) programs and services; (4) organization; (5) staffing; (6) bed facilities; (7) nonbed facilities; (8) site, and (9) financing.

For best planning results, the various decision areas should be analyzed in the order listed above because the decisions to be made then follow a natural logical sequence. Community need forms the natural basis for determining suitable hospital objectives. Hospital objectives, in turn, must be set before the programs and services required for carrying out those objectives can be determined. In the same way, decisions on organization and staffing depend on the programs and services to be carried out, while estimation of facilities requirements should be based on anticipated organization and staffing, as well as anticipated future programs and services. Similarly, estimates of financing requirements, for both operating and capital purposes, cannot be made satisfactorily until decisions have been reached regarding facilities, staffing and program needs of the future.

Once the long-range estimates or goals have been set in each of the main decision areas (and have been checked for consistency with one another), the planning problem becomes one of charting a series of feasible steps by which the selected goals can be achieved. Funds have to be raised, facilities built, staffs procured, programs and services developed, objectives reached and community needs met —all in accordance with a deliberate plan of accomplishment.

This brief sketch* of what is involved in the planning process, makes it apparent that long-range planning becomes more complex as the individual institution grows in size and diversity, and as the number of institutions serving the same community increases. Decisions in the two top decision areas, community need and hospital objectives, in particular, become increasingly difficult as a community's hospital system grows in complexity.

THREE TYPES OF PLANNING

Three main types of planning activity are discernible in the hospital field today: individual planning, cooperative planning and coordinated planning. Brief descriptions of these different levels of planning will help to clarify the role of each in achieving adequate area-wide planning for hospital care.

Individual planning is that done by a single institution in mapping out its long-range goals of community service and in determining the changes in programs and services, organization, staffing, facilities and financing that will be required to achieve those goals. Although all institutions must develop individual plans, this type of planning suffices as community-wide planning only in those situations where a relatively isolated community is served by a single hospital. In such cases, the hospital's service area is well defined, and the hospital has only to project into the future its community's total need for hospital care in order to obtain its own long-range goals.

A possibility for conflict between the community need and hospital goals can occur, however, when a one-hospital community grows large enough to perhaps justify the establishment of a second hospital. At that point, an existing hospital's vested interests in its own expansion program could run counter to the community's best interests if a second institution were needed for proper balance. Once a second hospital is established, individual planning (without reference to what the other institution may be doing or planning) is no longer an adequate guarantee that total community needs will be most effectively met.

*For a more detailed outline of the factors to be considered in hospital planning see Research Bulletins No. 3 and No. 4, Hospital Planning Council for Metropolitan Chicago.[3,4]

JOINT PLANNING

Cooperative planning is joint planning by two or more institutions in determining how the hospital care needs of an area served in common will be jointly met. In its most limited form, cooperative planning consists merely of "keeping each other informed". In its most advanced form, it would involve intensive planning conferences among hospitals serving the area for the purpose of arriving at a mutually satisfactory balancing of objectives, programs and services, staffing interrelationships, building plans and scheduled fund drives among the participating institutions.

Several important points about cooperative planning should be noted. First, even though it represents an important advance over individual planning, cooperative planning, too, becomes less effective as the number of participating hospitals increases. Second, cooperative planning, even at its highest level, does not necessarily lead to the best solution for a community's hospital care needs, but only to a solution that will be acceptable to most of the participating hospitals. Finally, under a cooperative planning arrangement, each hospital still pursues its own individual ends in its own way, with some adjustments for the plans of other hospitals, but without any over-all responsibility for seeing that the total hospital needs of the community are best met. Thus, cooperative planning, too, has its limitations.

COORDINATED PLANNING

Coordinated planning involves bringing the planning of all hospitals in an area into a harmonious relation for best achievement of total community needs as determined by a central planning agency. Under coordinated planning, total community needs are determined by objective research analy-

sis, and individual hospital planning is reviewed for consistency with these measured needs. Individual hospitals cooperate by voluntarily submitting their plans for review and by voluntarily agreeing to abide by recommendations of the central planning agency.

Under this type of planning arrangement, area hospitals gradually cease to function simply as a group of individual, independent institutions and begin to operate as a true hospital system by carrying out their individual planning within the framework of an area-wide plan. The unifying force behind this change is the central planning agency, which functions simultaneously as: (1) research center; (2) clearing house for planning information; (3) source of objective judgment on community need and hospital planning; and (4) arbiter for resolving possible conflicts of interest among area hospitals. These functions are usually carried out by the central planning agency as services for the hospitals and the community rather than by force of authority.

The foregoing descriptions of individual, cooperative and coordinated planning suggest that individual planning is adequate for relatively isolated areas served by one hospital; that cooperative planning is appropriate for areas with from perhaps two to six hospitals; and that coordinated planning is best for areas served by many hospitals.

Although it seems logical that as hospital systems become more complex they require a more comprehensive level of planning, the few facts available on current hospital planning indicate that relatively few hospitals have gone beyond the individual planning stage and those that do engage in some form of cooperative planning do so on a limited scale. Hospital replies to the previously mentioned long-range planning survey,[2] for example, showed that only 30 per cent of the responding hospitals took into account the plans of other hospitals to any great extent in their own planning. Only 17 per cent said that they participated in a community agency for coordinating hospital construction.

When the Hospital Planning Council for Metropolitan Chicago, for example, launched its program of coordinated planning in early 1959, the results of previous planning on an uncoordinated basis were all too evident. A typical example was the situation that existed in the northwest suburban section of the Chicago metropolitan area. As a result of the planned construction of six new hospitals and the planned addition of beds to two existing hospitals, it was found that within two and one-half years the number of beds in that area would have almost doubled, going from 1364 beds to 2645 beds. Of the six new hospitals being planned, several were to be located within 10 minutes driving time of one another. Only one of the proposed new hospitals was planning a school of nursing and no plans for the training of other needed technical personnel were in evidence. Each of these hospital organizing groups had recognized the genuine need for additional beds in that area, but each had approached the problem of providing those beds on an individual planning basis, with little or no reference to what other institutions were planning for the same area.

PLANNING MUST BE BROAD

Other examples that have come to us from people interested in developing planning agencies in other sections of the country indicate that similar kinds of problems exist in many metropolitan centers, particularly with reference to the rapidly growing suburban areas. The ironic part of this total situation is that many of these problems are caused by well intentioned, dedicated community groups who are intensely interested in providing their communities with adequate hospital care. But no matter how well meaning they are in their planning, these groups frequently create serious gaps and overlappings in community hospital services because their planning has been done on an individual basis and has not been coordinated in terms of broad, rather than local, community needs.

Another factor that reinforces the tendency toward individual planning by hospitals is the element of community pride. Each community, no matter how small, seems to want its own hospital. By concentrating on strictly local needs and desires, community planning groups frequently compound the problem by contributing to continued construction of greater numbers of small, minimum care hospitals instead of the few comprehensive care hospitals that could serve an entire area's needs most effectively and efficiently.

Although it seems to be true that hospitals as individual planning units have not moved very far in the direction of coordinated planning, hospital associations at the city, state and national level, as well as governmental agencies at the state and federal level, have become increasingly active in recent years in promoting area-wide planning. In addition, lay leadership groups of many communities have sparked drives for establishment of their own central planning agency for hospital care. This active interest on the part of hospital leadership groups and community leadership groups is evidence of increasingly wide recognition that some kind of over-all guidance for hospital growth is needed.

Since coordinated planning is the best way now known for providing this over-all guidance for a complex hospital system, and since it is also a relatively new development in the hospital field, it deserves special attention. Parts 2 and 3 of this article, scheduled to appear in the November 16 and December 1 issues of this Journal, will therefore be devoted to discussions of the important issues raised by this new concept, its advantages and disadvantages from both the hospital's and the community's points of view and the requirements for a successful program of coordinated hospital planning. ■

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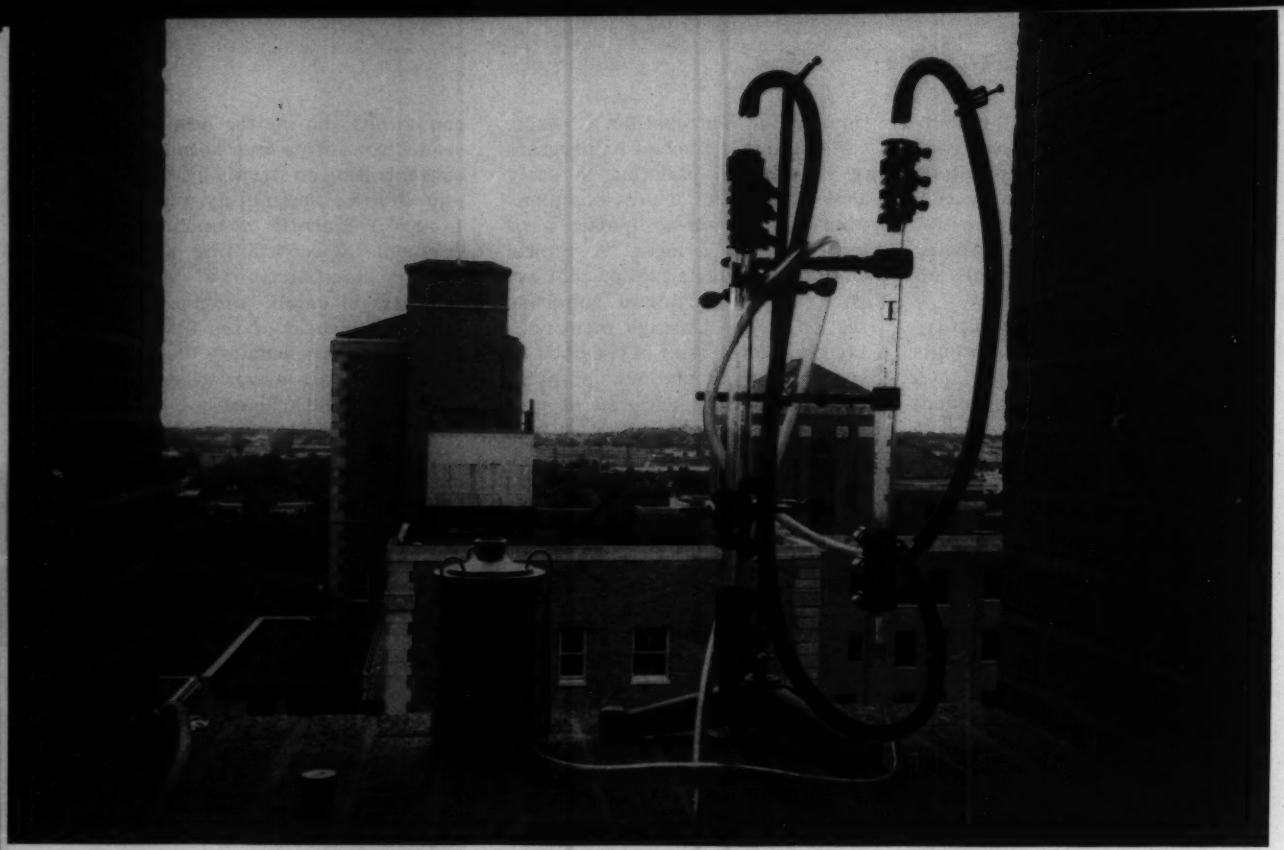
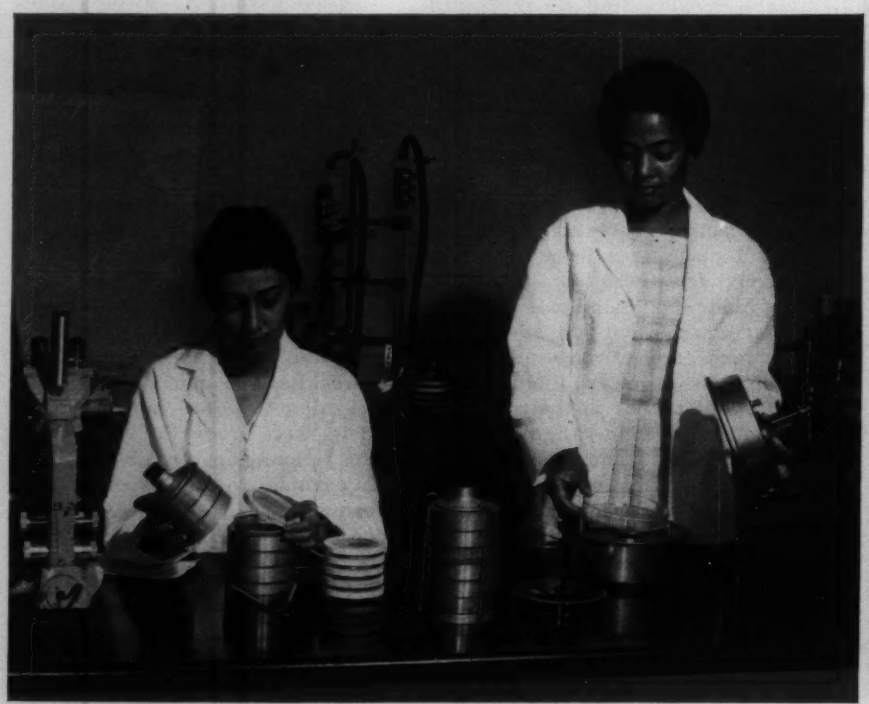


RECIRCULATION OF AIR IN THE SURGICAL SUITE

after four months of testing, investigators conclude that 80 per cent recirculated air in the surgical suite is bacteriologically safe



by HARVEY R. BERNARD, M.D., WILLIAM R. COLE, M.D., D.Sc., and JAMES C. CLAYWELL, B.S.M.E.

◀ (OPPOSITE PAGE) Outside air samples collected in a multistage sample from a 10th-floor vantage point facing prevailing winds during a seven-week period demonstrated that "fresh" air is not necessarily "pure" air.

(OPPOSITE PAGE AND BELOW) Collecting samples of air is easy, but analyzing them properly is painstaking work, although essential to a meaningful study of air contamination. A modern scientific laboratory provides the equipment necessary for accurate testing.

A NUMBER OF factors have brought the problem of wound sepsis to the attention of surgeons, hospital administrators and the general public. These factors include: (1) the "discovery" of the staphylococcus by the lay press; (2) the emergence of insensitive organisms resulting from clinical use of antimicrobial drugs; (3) the extension of surgery to the heart, and (4) the extension of operations to include the removal of multiple organs with great prolongation of surgical procedures.

Postoperative sepsis may be disastrous, particularly if it occurs in an operative wound through which the surgeon has manipulated blood vessels, bone, the heart, or the brain. This fact has led, in some hospitals, to poorly organized crash programs designed to eliminate sources of bacterial contamination. The measures taken in many of the programs are largely founded on theoretical bases without supporting scientific observations.

One of the more obvious theoretical sources of bacterial contamination is the air which surrounds all surgical procedures. In the past, several authors have suggested that airborne bacteria play an extremely important role in the contamination of clean wounds which unexpectedly become infected.[1-3] The result has been that many mechanical devices have been designed and sold to rid the air of its bacterial contamination. Laws have been passed, with comparatively meager scientific basis, which force new hospitals to adopt air conditioning devices and direct the manner in which the air must be used. In some states, these laws extend to the regulation of air handling in existing hospitals.[4] Blind acceptance of these decrees results in great expenditures of public funds for the purchase of complicated air handling devices on a purely theoretical basis.

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This study was aided by a grant from the John A. Hartford Foundation.

LEGAL STIPULATIONS

The laws of some states require the use of controlled circulation of the air with the prohibition of recirculation of the air in such critical areas as nurseries, delivery rooms, operating rooms and emergency rooms.[4] The Hill-Burton hospital authorities will not permit the use of governmental funds for the construction of new facilities without provision for an all-outside air supply.[5] Despite these regulations, many of the hospitals in the United States use air conditioning systems for the purpose of providing comfort alone. Through a large part of the year, there is no forced circulation of the air and there is no filtration. If it is important that the air be circulated as required by the governmental program for new hospitals, then it would seem to be equally important to enforce similar rules for old hospitals. However, very few data are available which make such legislation seem desirable.

This paper will present data, obtained under operating conditions in the Barnes Hospital, which relate to bacterial content of the outside air and its adaptability for use within operating rooms. Data will also be presented regarding the bacterial content of recirculated operating room air under conditions of normal use. The cost of air conditioning with 100 per cent outside air, or "fresh air", will be compared to the cost of a system of recirculation which provides 20 per cent outside air.

STUDY METHODS

For seven weeks, the outside air of the Barnes Hospital was sam-

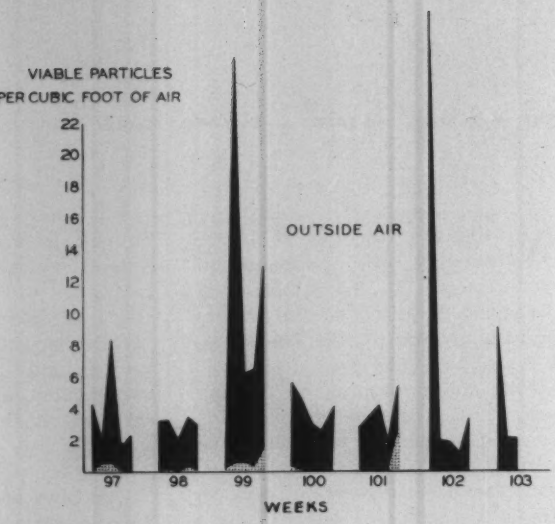

FIGURE 1. This is a graphic demonstration of the remarkable variations which were observed in quantitative samplings of the bacterial content of outside air made 10 floors above street level. The solid area represents the total number of viable bacteria; the stippled area represents particles carrying coagulase positive staphylococci.

pled at a tenth-floor vantage point which faces the prevailing winds, although it is protected from the elements during inclement weather. Data obtained from this study have been compared with similar data obtained in two test operating rooms. The Andersen multistage sampler was used as the collecting device for all these experiments.[6] The samples have been taken on soy trypticase and tellurite glycine agar. Ten cubic feet of air have been sampled, with each sampling at a rate of one cubic foot per minute. For four months, one of us (J.C.) tabulated the temperatures required to maintain comfortable surroundings for the operating room personnel. The costs of the

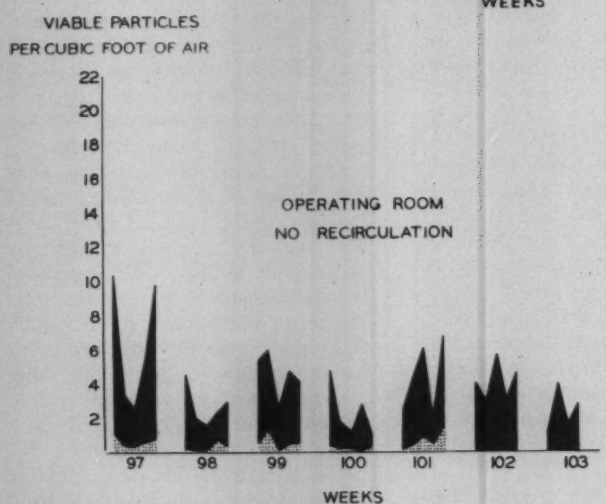

FIGURE 2. This is a graphic representation of the degree of bacterial air contamination observed in operating room A. In this operating room, the air is filtered by an electronic precipitator, delivered to the operating room and discharged without recirculation. The solid areas refer to total viable bacterial particles; the stippled areas refer to particles carrying coagulase positive staphylococci.

STRICT isolation measures are employed to prevent the spreading of infectious materials and agents, which can produce a hospital-wide environmental sepsis if not controlled.

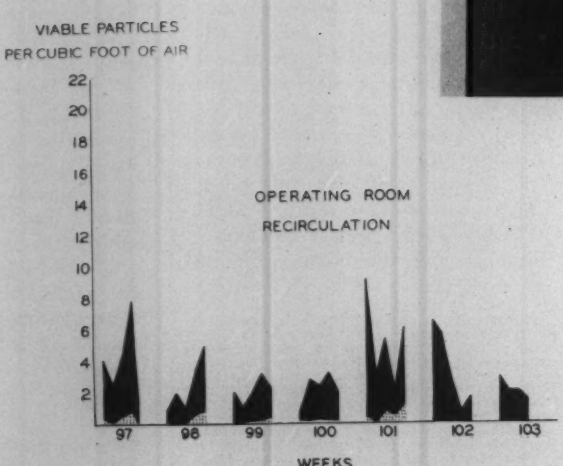

FIGURE 3. This is a graphic representation of the degree of bacterial air contamination observed in operating room B. During these tests the air was filtered through a spun glass prefilter and a high efficiency dry filter before it was delivered to the operating room. Thereafter, 80 per cent of the air was recirculated through these filters.

various forms of air processing used in the operating rooms have been derived by using data obtained from the United States Weather Bureau Meteorological Station and the costs of electrical power to the Barnes Hospital.

STUDY RESULTS

Figure 1, page 48, gives a graphic representation of the number of bacteria-carrying particles which were found in the outside air and compares the total number of viable particles with those carrying coagulase-positive staphylococci. Figure 2, page 48, shows a similar graph which describes the total number of viable bacterial particles and the total number of coagulase-positive staphylococcus-carrying particles within an operating room supplied by 100 per cent outside air. The third figure, page 48, shows the total air contamination in another room by viable bacterial particles and staphylococcus-bearing particles. This other room is serviced by an air conditioning system which provides for replacement of 20 per cent of the air with outside air as it passes through the circulation equipment. The equipment accomplishes a complete circulation of air eight times an hour. All air is passed through dry F.G. 50 media* as it leaves the air conditioner.

During the four months studied, the temperature of a group of four operating rooms was controlled by a single individual (J.C.), to whom all complaints were directed. When the temperature fell below 68° F., the nurses complained of being cold. As the temperature rose above 73° F., the surgeons complained of being warm. During this test period, a temperature of 70° F. was found to be most universally acceptable to the personnel in the operating rooms. The design conditions of the operating room facilities of the Barnes Hospital are listed in Table 1, above.

Data which compare the costs of circulating 100 per cent outside air through the operating room at a rate of eight air changes per hour with the costs of recirculating at a rate of eight air changes per hour and the addition of only 20 per cent outside air with each passage are listed in Table 2, below.

*American Air Filter mechanical dry filter media of 90-95 per cent discoloration efficiency.

TABLE 1

The equipment described was designed to produce operating room conditions as follows:

EQUIPMENT PERFORMANCE	OUTSIDE SUMMER CONDITIONS	OUTSIDE WINTER CONDITIONS
70° F. dry bulb 60° F. wet bulb 60 grains of moisture per lb. of dry air	95° F. dry bulb 78° F. wet bulb 118° of moisture per lb. of dry air	-20° F.

If provision is made for the supply of 100 per cent outside air, the cost of air conditioning equipment for 14 operating rooms at Barnes Hospital is approximately $64,000. These costs are only $22,000 (a difference of $42,000) if 80 per cent of the air is recirculated. During each year of use, 100 per cent outside air circulation would cost $3500 more than 80 per cent recirculation. This saving alone, accumulated yearly for 6.6 years, would equal the total cost of the equipment needed for 80 per cent recirculation in 14 operating rooms. In these calculations, no attempt has been made to estimate the additional maintenance cost which would probably be required in the handling of the larger air conditioning equipment, or the additional space that would be required for its use. Neither are there any figures included which relate to the cost of the installation of this equipment. (In many instances this cost approximates the original cost of the equipment.)

DISCUSSION OF PROBLEM

Pertinent questions regarding bacterial air contamination in operating rooms are: (1) How much bacterial air contamination is permissible before it constitutes a significant hazard to patients and personnel? (2) What are the methods of air handling which will best control air contamination with bacteria and not interfere with the other prerequisites of an efficient air conditioning system?

With reference to the first question, it is difficult to establish

TABLE 2—AIR CONDITIONING EQUIPMENT COSTS

	(100 Per Cent Outside Air—No Recirculation)	(20 Per Cent Outside Air—80 Per Cent Recirculation)
Tonnage Required	140	60
Central Unit Cost	$29,170*	$11,366*
Room Units Cost	$35,510†	$11,200†
	$64,680	$22,566

Difference $42,114 (initial)

YEARLY OPERATING COSTS

Air Conditioning	$ 3513‡	$ 1185‡
Heating	$ 1816§	$ 640§
	$ 5329	$ 1825

Difference $3504 (yearly)

*Includes compressor, motor and controls; evaporative condenser and receiver; water chiller and water circulating pump.
†Includes cooling coil, heating coil, controls, fan and fan motor.
‡Air conditioning costs are based upon U.S. Weather Bureau Climatological Data Supplements* which permit calculation of the yearly number of hours of temperatures varying from 70° F. to 100° F., which were experienced in St. Louis. The kilowatt hours of electricity required to bring these temperatures at 60 per cent average relative humidity to our design conditions were multiplied by our electrical costs (1.8 cents per kilowatt hour) to give the total electrical costs.
§The heating costs were calculated on a degree day basis.*

minimal safe standards for devices and equipment which are to be used in the treatment of human beings. Unfortunately, too little scientific study has been done to determine what the significant levels of operating room bacterial air contamination are. This problem, of course, is related to lack of knowledge of the true causes of postoperative wound sepsis.

These questions will eventually be answered by careful comparison of the frequencies of postoperative wound infections with accurate quantitative measurements of the number of bacteria in the air.

Although the answers to the second question are somewhat dependent on a knowledge of how much bacterial air contamination is permissible, certain facts are known which permit a practical temporary solution to the problem. An ideal air conditioning system should provide a comfortable, pleasant, safe atmosphere in which the surgeons may work. This means an atmosphere which is free of noxious fumes and explosive vapors and relatively free of bacterial contamination. This air should also be supplied at a humidity which produces a low spark potential and is still comfortable for the occupants.

USE OF the sampler during a surgical procedure furnishes data which enable the hospital cross-infections team to direct its attack on the problem of postoperative wound sepsis most efficiently and effectively.

The results of bacterial sampling of the air of the Barnes Hospital has indicated that the outside air is far from pure and uncontaminated. There are remarkable and unpredictable variations in the total number of viable particles as well as staphylococcus-bearing particles. It is obvious from considering these results that some type of filtration is necessary before the bacterial content of outside air can be held at a consistently low level and be considered safe for use in operating rooms.

TEST FINDINGS

At the Barnes Hospital, during a four-month test, bacterial air contamination was as well controlled in an operating room in which 80 per cent of the air was recirculated through an inexpensive dry filter as it was in a second operating room in which the air was provided after filtration through a large electrostatic filter and discarded after one passage. During the test, the average number of bacterial particles remained below five per cubic foot in both rooms, and a ratio of one coagulase-positive staphylococcus-bearing particle to 300 of all other viable bacterial particles has been maintained.

Cost analysis of the use of 100 per cent outside air as compared to the cost of 80 per cent recirculated air indicates that recirculation is much less expensive.

The fire regulations pertaining to the explosiveness of gas-air mixtures has been somewhat relaxed in recent months by the National Fire Prevention Association.[7] The code currently states:

"Available data and recent investigations indicate that under customary operating procedures, flammable anesthetic mixtures are diluted by air in the anesthetizing area to a nonflammable range before reaching a vertical height of one foot from any source of leakage or spillage involving quantities of anesthetics used in anesthesia procedures. These findings . . . provide a sound basis for the statement that *recirculation of air in ventilating systems serving anesthetizing locations does not increase the hazards of fire and explosions from flammable anesthetic vapors.*"

No disadvantages to the use of 80 per cent recirculated air have been observed during this study. Maintenance of a relative humidity in excess of 50 per cent is facilitated by recirculation of the air.

Recirculation of air in operating rooms and other areas in hospitals where control of airborne bacteria is considered important has been prohibited by several forms of legislation. These controls were invoked on the assumption that recirculation was dangerous because of hazards relating to airborne bacteria and to explosions of anesthetic gases. Since neither of these assumed hazards appear now to be related to recirculation of air, and since recirculation of air is advantageous in many respects, recirculation of air, at least in surgical operating rooms, should be permitted. ■

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HOW NOT TO BE AN EFFECTIVE SUPERVISOR

by EDITH ARLEN

THE KEY to effective on-the-job performance is motivation. The key to motivation is held by the supervisor. He must know and understand the people in his work group; he must observe them well; he must communicate with them; he must evaluate their performance; and he must help them improve their performance.

But sometimes supervisors, because they are also people with their own needs, goals and motivations, fall short of developing the kind of sensitivity and understanding for the employee that will bring forth efficiency and improved performance. Some of the common supervisory mistakes that should be avoided are included in this "rogue's gallery" of undesirable supervisors.

THE PERFECTIONIST

The "perfectionist" is the supervisor who runs himself and the employees in his department ragged because he wants everything to be perfect. He thinks that everything must be done immediately and that everyone must do everything the way he would do the job. He often and easily forgets that not everyone has the same skills, intelligence, or interest in the job. When this type of supervisor institutes changes, he often works too fast, so that it is difficult for his employees to keep up with him, to understand the changes, or to know what they really mean.

This kind of a supervisor must recognize that nothing can be on an all or nothing basis, that no solution is perfect, that there always are—and always will be—problems for which there is no "ideal" solution.

THE SHIFTER

The "shifter" is the supervisor who perpetrates inconsistencies. One day he is all "sweetness and light"; the next he is "old grouch" and no one can do anything that will please him. Employees find this kind of supervisor very difficult to work for because he is so unpredictable.

This supervisor has to learn to consider acceptable alternatives. He must learn to avoid "off-the-cuff" decisions, so that he understands—and the people who work for him learn—what the baseline for his judgment is and what to expect.

THE VICTOR

The "victor" is the supervisor who must always be right—at all costs. He cannot bear to be wrong. This is the kind of supervisor who will often handle problems on a first-come-first-served basis—whatever comes up he will try to handle without considering the alternatives and consequences. Very often, this supervisor becomes a "shifter" because he feels that he must respond to immediate pressures. Often he tends to ignore the long-run effects of his decision; often he forgets that his decisions affect others.

THE WORRIER

Another type of supervisor who is difficult to work with is the "worrier". This supervisor is terribly concerned about everything and everyone and often tends to exaggerate the situation.

This supervisor has to learn not to overemphasize incidents and problems. He must learn to use judgment about what needs to be done and how it should be done in a timely, considerate way.

THE BIG WHIP

The "big whip" is the kind of man (or woman, because they often are like this) who is harsh, strict and "real tough". This type often is a perfectionist, who always must be right and always knows all the answers. This supervisor often believes that the only way to get the work done is to tell people what to do and how to do it.

This kind of supervision tends to stifle initiative and any kind of communication. "If he knows all the answers, why should I tell him? He isn't interested anyway!" "If he tells me what to do and how to do it, why should I use my own head in doing my job? Even if I do, he won't like it and I'll be criti-

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cized!" These are common reactions to authoritarian supervision that allows no room for acknowledgment of individual skills, abilities, or self-expression.

THE BUDDY-BUDDY

The "buddy-buddy" supervisor goes to the other extreme. He wants to be "friends" with everybody in his work group. He thinks he can win people over by pretending to be friendly and kind and by attempting to manipulate them into doing their jobs.

This backfires as much as the "big whip" kind of supervision. Employees begin to distrust the man, in the belief that "he doesn't mean what he says anyhow, so why should I pay any attention to him?" They begin to feel that he is really dishonest in his pretended interest in them. At the first opportunity, they turn against him.

What this supervisor needs to learn is how to gain the confidence and respect of employees. He must deal with them fairly and in an "above-the-board" fashion. Only when he proves to them that he means what he says and says what he means will his employees become an efficient, smooth-working team.

Most supervisors are interested in improving the performance of their employees. But in order to do this, they must strive to improve their own performance as well. The two are interdependent and closely related. ■

AN AMERICAN ADMINISTRATOR REPORTS ON BRITISH HOSPITAL MEETING

Harlen Paine Jr., former administrator of the Winchester (Mass.) Hospital and now director of the American University Hospital, Beirut, Lebanon, went to London early last summer to attend the Annual Institute for Hospital Administrators, held in conjuction with the International Hospital Equipment and Medical Services Exhibition. Following are some of his impressions of the meeting.

Great Britian's annual gathering of hospital administrators is small by American Hospital Association convention standards. It consisted of single sessions devoted to the future of the nursing profession, medical auxiliary staffing, the provisions of "hotel" services and administrative staffing.

ENTHUSIASM OVER P.P.C.

The discussion in the nursing session was reminiscent of nursing meetings several years ago in the United States. The British, too, are concerned about the shortage of nurses. They have 160,000 full-time graduate nurses in the United Kingdom, and nursing administrators are plagued with the usual problem of marriages, pregnancies and the loss of nurses to higher paying industrial jobs. They are also concerned that nursing skills are being wasted on non-nursing jobs, and they are urging the Ministry of Health to conduct job evaluations so that nursing skills can be more effectively utilized.

The British are just now apparently becoming aware of the progressive care concept. Several speakers who had recently returned from the United States, where they had studied our experience, urged British administrators to consider such a plan not only for its value to the patient but also as a means of better utilization of available personnel. References were made to the need of understanding the patient's mental and emotional problems as well as his physical problems, and how hospitals should attempt to provide "extras", such as telephones, pleasant lounges and more liberal visiting regulations.

Satisfactory food systems are a problem that the British have not completely solved. They have investigated the American ideas, but they tend to reject them as being too complicated and too mechanical. One speaker even made the comment that they should not look to America for a solution to their food problem, since their taste required much hotter food than we serve. The British are interested in the American trend of removing food services from nursing supervision and assigning it to dietary personnel, but there was not much sympathy for this idea expressed at the meeting.

DISSATISFACTIONS EXPRESSED

In every session there seemed to be a constant undercurrent of dissatisfaction on the part of hospital officials and the local boards with the Ministry of Health. Morale among those who are actually running the hospitals appeared to be low because they felt that the officials in the Ministry, while determining the policies, setting their wage rates and establishing their budgets, had little understanding of the real problems of the hospitals.

Administrators appeared resentful over the minor role that they, in most cases, play in the administration of the hospital. A year or two ago, a law was passed assigning hospital administrators the authority similar to that an American administrator has, but in spite of this law, the Ministry continues to assign major executive authority to hospital medical superintendents, while the administrators are limited to management of the "hotel" services.

One discussion topic that offset the atmosphere of dissatisfaction was the government's plan to spend £500 million during the next 10 years replacing hospital facilities. The expenditure is not expected to produce many more beds, but is intended mainly to replace the ancient physical structures now common in the British hospital system.

In spite of all the critical discussions, the hospital officials seemed to be making real progress in solving their problems. It was particularly impressive that the main motivation for all their complaints and recommendations was centered around better care for the patient. ■

CHECK LIST FOR EDUCATIONAL PLANNING

AMERICAN HOSPITAL ASSOCIATION INSTITUTE SCHEDULE FOR 1962

A calendar of institutes and meetings appears in each issue of this Journal on page 6. This calendar may be checked to determine unanticipated changes in schedule and specific location for each institute.

SUBJECT	NAME OF INSTITUTE	DESCRIPTION	CITY & DATE	FEE PER PERSON
ADMINISTRATORS' SECRETARIES	Institute for Administrators' Secretaries	Designed to emphasize the skills necessary to be an effective administrator's secretary, with particular reference to communications, human relations, office management and hospital problems.	Chicago, July 18-20	$45*
AUXILIARIES	Institute on Patterns and Principles for Auxiliary Leaders	Designed to assist auxiliary leaders, present and potential, in meeting the responsibilities of their positions. The program concentrates on the functions and concerns of a leader in guiding an effective hospital auxiliary.	Los Angeles, June 5-7	$40
CHAPLAINCY	**Institute on Hospital Chaplaincy Programs	The methods and techniques of establishing a chaplaincy program will be studied, along with the purposes of the program and the management of such program. This institute is for hospital administrators, members of the clergy, trustees and physicians interested in such a program.	Chicago, June 27-29	$45*
CREDITS AND COLLECTIONS	Institute on Credits and Collections	See: FINANCIAL MANAGEMENT	Chicago, July 24-25 Boston, October 15-16	$33.50* $30
DENTAL SERVICE	Basic Institute on Hospital Dental Service	Conducted cooperatively with the American Dental Association. Designed for dentists practicing in hospitals, hospital administrators and physicians interested in developing dental service in hospitals. Includes sessions on responsibility for good patient care, relationships within the hospital and outpatient dental service.	Detroit, May 14-17	$40
	Advanced Institute on Hospital Dental Service	Primarily for those who have attended one of the previous institutes on hospital dental service. Will be geared to specific problems in the administration of hospital dental service and will be of special interest to administrators and dentists who have worked with an organized dental department.	Chicago, November 27-29	$45*
DESIGN AND CONSTRUCTION	Institute on Hospital Design and Construction	An institute conducted for persons engaged in hospital planning, professionally, administratively, or as committee members, so that new developments in hospital design and construction can be explored and discussed.	Miami Beach, Fla., November 26-29	$40
DIETARY SERVICE	Institute on Dietary Department Administration	Designed to assist administrators, food managers and dietitians with improved dietary administration. Projects submitted by registrants will be discussed. These programs are conducted in cooperation with the American Dietetic Association.	Pittsburgh, January 8-12 Denver, May 7-11	$45 $45
	**Institute for Cook Managers and Food Service Supervisors	This program will offer practical assistance in planning, directing and coordinating a dietary department in the absence of a qualified dietitian. Food service supervisors who direct dietary departments may attend.	Chicago, August 6-10	$53*
DISASTER PLANNING	Institute on Disaster Planning	This program is conducted for all hospital personnel responsible for or interested in disaster operations within the institution as well as in the community. It covers radio communications, disaster planning and practical operation of the written disaster program.	Chicago, August 22-24	$45*
ENGINEERING	Institute on Hospital Engineering	Designed for hospital administrators, engineers, members of the administrative staff who are concerned with the engineering aspects of hospital operation and for persons professionally engaged in hospital planning.	Chicago, April 16-20 New York City, October 15-19	$53* $45
FINANCIAL MANAGEMENT	Institute on Hospital Budgeting	Directed to administrators and others responsible for the financial management program of the hospital. The theories and procedures necessary to develop a formal budget will be presented in a series of lectures and group discussions.	Chicago, February 12-14	$45*
	Institute on Credits and Collections	A program designed to study credit and collection policies and procedures for both large and small hospitals. Techniques required to attain better credit management and increased collections will also be presented.	Chicago, July 24-25 Boston, October 15-16	$33.50* $30

*Includes luncheons **Tentative

SUBJECT	NAME OF INSTITUTE	DESCRIPTION	CITY & DATE	FEE PER PERSON
FINANCIAL MANAGEMENT (continued)	Institute on Machine Accounting and Data Processing	A three-day program directed to administrators and other responsible individuals to study automatic data processing applications and systems. Design techniques and other unique requirements to develop a sound and effective automated program will also be considered.	Chicago, May 7-9	$45*
HOSPITAL SOCIAL WORK	Institute on Essentials of a Hospital Social Service Department	Conducted in cooperation with the National Association of Social Workers. Designed to serve as a guide to the administrative considerations for establishing and developing social service departments and directed toward those experienced personnel responsible for developing social service departments in hospitals and related institutions.	Chicago, December 10-13	$46.50*
HOUSEKEEPING	Basic Institute on Hospital Housekeeping	Designed to assist housekeepers, administrators and members of the hospital staff concerned with the operation of the housekeeping department in improving the effectiveness of their housekeeping department. The program will focus on the functions and considerations involved in its operation and organization.	Chicago, May 21-23	$45*
	Advanced Institute on Hospital Housekeeping	For executive housekeepers and other staff members concerned with the operation of the housekeeping department. The program will be directed toward the study of good management techniques and their application to housekeeping operation.	San Francisco, November 5-7	$40
INSURANCE	Institute on Hospital Safety and Insurance	For those responsible for the hospital's safety program or for purchasing the insurance coverage. Joint attendance is urged when more than one person is responsible for these activities. The institute is designed to illustrate the causes of hospital incidents and accidents; to demonstrate how incidents and accidents affect insurance and other costs; to outline the protection provided by insurance; and to propose a practical hospital safety program.	Chicago, November 5-7	$45*
LABOR	Institute on Labor Relations	Designed to acquaint hospital administrators, personnel directors and trustees with the latest developments and trends in the labor relations field. Program will include both lectures and small group discussions.	Chicago, March 19-21 Denver, July 30-August 1	$45* $40
LAUNDRY	Institute on Hospital Laundry Management and Operation	For hospital administrators, laundry managers and other staff personnel who are concerned with the operation of the hospital laundry. The program will deal with ways to improve the laundry department of a hospital, covering subjects such as departmental relationships, improved work procedures, management principles and new laundry equipment.	Kansas City, Mo., September 26-28	$40
LAW	Institute on Hospital Law	For hospital administrative staff, trustees, hospital attorneys and department heads concerned with the legal aspects of hospital operation, such as medical record librarians or supervising nurses. Provides opportunities to consider the legal implications of hospital activities and to exchange information on hospital law.	Philadelphia, May 14-16 Chicago, December 17-19	$40 $45*
LIBRARIANSHIP	Institute on Hospital Librarianship	For librarians without formal training in library science who have responsibility for medical, nursing school, or patients' libraries in hospitals. Instruction covers classification, cataloging, selection, acquisition, reference, circulation and public relations. Emphasizes library organization, with workshops on technical procedures.	New York City, October 8-12	$45
MANAGEMENT	Institute on Hospital Organization	Designed to help administrators keep pace with progress in hospital management through the discussion of administrative—board—medical staff organizational problems and an analysis of the tools and techniques of management used to increase administrative effectiveness.	New Orleans, October 8-10	$40
	Institute on Management Development	For hospital administrators, personnel directors and others responsible for administering a management development program in the hospital. Considerations involved in planning, organizing and conducting such a program will be discussed.	Chicago, October 8-10	$45*
	Institute on Administration and Organization of Medically Directed Departments	Designed for hospital administrators, assistant administrators and chiefs of departments of radiology, anesthesiology, laboratories, etc., this institute will cover administration and organization of departments directed by physicians.	Chicago, October 1-3	$45*
MEDICAL RECORDS	Specialized Institute for Medical Record Librarians on Organization and Management	Conducted in cooperation with the American Association of Medical Record Librarians. Designed to help medical record librarians with administrative responsibilities through lectures on how to provide personnel with skilled leadership and how to use personnel's aptitudes and interests to obtain maximum efficiency.	Chicago, February 5-9	$53*
	Specialized Institute on Hospital Statistics for Medical Record Librarians	Conducted in cooperation with the American Association of Medical Record Librarians. Lectures will be presented on uniform definitions and methods for gathering and reporting statistical information. Data gathering equipment will be demonstrated and there will be practice sessions in applying the principles and methods in obtaining uniform hospital statistics.	Chicago, August 13-17	$53*

*Includes luncheons

SUBJECT	NAME OF INSTITUTE	DESCRIPTION	CITY & DATE	FEE PER PERSON
MEDICAL RECORDS (continued)	Special Subject Institute for Medical Record Librarians on International Classification of Diseases and Operations	Devoted to instruction in principles of International Classification of Diseases and Operations as adapted for hospital indexing. Included will be lectures on classification and practice sessions under direction of experienced instructors, with discussion sessions on indexing methods.	Chicago, April 4-6	$50-55*
	Basic Institutes for Medical Record Personnel	Conducted by the American Association of Medical Record Librarians in cooperation with the American Hospital Association, these programs are designed for the nonregistered medical record department employee. Lectures and small discussion groups provide basic instruction in medical record procedures, medico-legal aspects of medical records, statistics, anatomy, disease and operation nomenclature, classification and indexing.	Chicago, June 11-15 Washington, D.C., November 12-16	$60-65* $50-55
METHODS	Advanced Institute on Methods Improvement	Limited to administrators, methods engineers and methods coordinators from hospitals which are currently conducting full-time organized methods improvement programs. Discussion will include various ways in which industrial engineering techniques have been applied in the hospital, analysis of successes and failures and proposed new applications.	Baltimore, April 2-4	$40
	Basic Institute on Methods Improvement	Designed to assist the hospital administrator in developing an organized methods program. Approaches to organized methods improvement in hospitals, considerations involved in planning, organizing and conducting a program and some of the fundamental techniques of industrial engineering will be discussed.	Chicago, August 27-29	$45*
NURSING HOMES	Institute on Nursing Home Administration	Conducted in cooperation with the American Nursing Home Association and American Medical Association. Subjects will include fundamentals of management, planning new facilities, personnel practices, medical supervision and nursing care of the chronically ill and aged, medical records, and legal aspects of patient care.	Miami Beach, Fla., March 27-30 Boston, October 2-5	$40 $40
NURSING SERVICE	Institute on Central Service Administration	Provides the central service supervisor with the opportunity to review and evaluate newer trends in the management of the central service department. Both technical and supervisory techniques and procedures will be explored.	Minneapolis, October 29-November 2	$45
All nursing institutes are conducted in cooperation with the Department of Hospital Nursing of the National League for Nursing.	**Institute on Emergency Room Nursing Service Management	The purpose of this institute for the emergency room supervisor will provide the opportunity to study tested procedures utilized in improving the efficiency of the services offered in the emergency room. This is the first institute conducted in this clinical area.	Chicago, March 5-8	$46.50*
	Institute on Evening and Night Nursing Service Administration	A program planned for permanently assigned evening and night supervisors who are delegated administrative functions and the responsibilities for the supervision of patient care for two-thirds of the hospital day. Designed to explore and evaluate supervisory tools and techniques needed to interpret and carry out hospital policies and procedures.	Chicago, March 26-29	$46.50*
	Institute on Nursing Inservice Programs	Emphasizes planning objectives and teaching techniques rather than course content. Designed for inservice coordinators or directors, directors of nursing or hospital staff personnel responsible for planning and coordinating newly developed or ongoing inservice educational programs.	Chicago, December 3-6	$46.50*
	Institute on Nursing Service Administration	Designed for directors of nursing service and hospital administrators. Newer trends in nursing service administration will be reviewed and evaluated. Proven administrative practices will be shared and mutual problems discussed. Attendance by both the director of nursing and the administrator is urged.	Memphis, Tenn., January 22-26 San Francisco, February 5-9	$45 $45
	Institute on Nursing Service Supervision	Emphasis on the development of leadership skills, definition of responsibilities and planning and organizing work. This institute is designed for nursing service supervisors in all clinical specialties within the department of nursing service. No more than two applications accepted from a single hospital.	Chicago, June 4-7 Pittsburgh, October 15-18	$46.50* $40
	Institute on Obstetrical Nursing Administration	For supervisors actively engaged in the over-all administration of the obstetrical nursing service. Directed toward development and evaluation of the administrative skills and techniques demanded of this specialty.	Buffalo, N.Y., April 30-May 3	$40
	Institute on Operating Room Administration (advanced program)	For supervisors actively engaged in the over-all administration of operating room nursing service. Designed to provide management tools which will enable the supervisor to perform her supervisory functions with a greater degree of proficiency and satisfaction.	Chicago, September 24-27	$46.50*
	Institute on Staffing Departments of Nursing Units	To assist the director of nursing service and the hospital administrator in the re-evaluation of present-day staffing patterns. Methods of assignment and control, personnel selection and evaluation of nursing needs will be reviewed. Joint attendance by directors of nursing service and administrators is urged.	Chicago, April 9-13	$53*

*Includes luncheons **Tentative

SUBJECT	NAME OF INSTITUTE	DESCRIPTION	CITY & DATE	FEE PER PERSON
OCCUPATIONAL THERAPY	Institute for Occupational Therapists	Conducted cooperatively with the American Occupational Therapy Association, this institute emphasizes the management responsibilities of the occupational therapist as a department head. Geared to the needs of both smaller and larger hospitals.	Cleveland, May 21-23 or Cincinnati May 7-9	$40
PERSONNEL	Advanced Institute on Personnel Administration	This institute is designed to provide information concerning technical aspects of wage and salary administration. Sessions will be devoted to the role of the personnel department in the employees' grievance procedure, and time will be allocated to human-relations problems.	Louisville, Ky., February 19-21	$40
	Basic Institute on Personnel Administration	Designed to assist hospitals in the development of a sound personnel program. The program will focus on the functions of a personnel program and considerations in planning and implementing it. The basic aspects of employee relations will be reviewed.	Cleveland, June 25-27	$40
PHARMACY These institutes are conducted in cooperation with the American Pharmaceutical Association and the American Society of Hospital Pharmacists	General Institute on Hospital Pharmacy	Principles, techniques and procedures will be discussed. Administrative and technical aspects of hospital pharmacy will be included. Small group discussion sessions will develop means of implementation in hospitals of various sizes.	Boulder, Colo., June 25-29	$47.50 (includes a university charge, per student, over the Association's regular $45 fee)
	General Institute on Hospital Pharmacy	See description on Boulder, Colo. institute.	Pittsburgh, August 13-17	$45
	Specialized Institute on Hospital Pharmacy	Intended primarily for those who have attended previous general institutes on hospital pharmacy. Designed to treat one particular aspect of hospital pharmacy practice in depth.	Chicago, October 15-19	$53*
PHYSICAL THERAPY	Institute for Physical Therapists	Conducted in cooperation with the American Physical Therapy Association. Emphasizes the management responsibilities of the physical therapist, the rehabilitation team and the development of communication skills. Professional problems will be discussed in group sessions.	Chicago, October 29-November 2	$53*
PURCHASING	Advanced Institute on Hospital Purchasing	The program delves into the more advanced aspects of hospital purchasing. Emphasis will be placed on problem-solving sessions designed for the more experienced purchasing agent.	Baton Rouge, La., March 13-16	$40
	Institute on Hospital Purchasing	Basic institute covers storeroom procedures, inventory control, ethics and purchasing reports as well as other fundamentals. Instructional conferences, group discussions and problem solving sessions will be emphasized in this program.	Buffalo, N.Y. July 9-13	$45
	**Institute on Purchase of New Equipment for New Construction	This program is conducted for hospital purchasing agents and engineers. It is designed for the individuals responsible for the purchase of new equipment. Emphasis is placed on the purchase of capital equipment. Attendance by both the purchasing agent and the engineer is encouraged.	Chicago, September 4-7	$46.50*
SAFETY	Institute on Hospital Safety and Insurance	See: INSURANCE	Chicago, November 5-7	$45*
SUPERVISION	Institute on Supervision	Designed for hospital staff members who spend the majority of their time directing the work of others, regardless of the department, to develop managerial and leadership skills and attitudes which will enable them to perform their work more effectively. Multiple attendance from the same hospital is encouraged.	Chicago, May 14-16	$45* for one registrant $29* for second registrant from same hospital. $17* for additional registrants from the same hospital, after the first two.
TRUSTEES	**Institute for Hospital Trustees	These institutes will spell out the responsibilities inherent to both hospital administrators and hospital trustees in the voluntary hospital. Emphasis will be placed on the financial, legal and administrative responsibilities.	Chicago, April 23-25 Philadelphia, December 3-5	$45* $40
VOLUNTEER SERVICE	Advanced Institute for Directors of Hospital Volunteers	Administrative problems of the volunteer service department analyzed at the policy level; new developments in hospital care and their counterparts in volunteer service. Enrollment limited to the experienced director of volunteers (salaried or unsalaried). Attendance at an AHA Basic Institute for Directors of Hospital Volunteers is required.	Chicago, March 12-14	$45*

*Includes luncheons **Tentative

EXCEPT in small areas, such as closets, where a ruler was used, all dimensions in the study hospitals were measured with a measuring wheel device.

MEASURING HOSPITAL CAPACITY FOR MODERN PATIENT CARE

by PAUL A. LEMBCKE, M.D., and ELEANOR POLAND, Ph.D.

The steadily increasing demand for hospital care is usually absorbed for a time by crowding in extra beds beyond the normal capacity of patient rooms and by overloading the adjunct and service departments that are highly essential to proper hospital care, the authors state. They describe a simple method for determining the normal capacity of all departments which provides an early warning of the crowding and overloading and indicates the necessity for both immediate and long-range planning for expansion.

ADEQUATE space for the essential departments of the hospital is closely related to efficiency and safety of operation. Every hospital should know just where it stands on the matter of adequate space, but it is of even greater importance to hospitals that contemplate replacing or adding to their buildings. These hospitals need a standard method of determining whether the space in the patient rooms is adequate for modern hospital care and whether the space in their basic hospital departments is sufficient to support the number of beds.

These essential facts, which can be learned by using the method described in this article, present a clear picture of current space de-

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This investigation was partially supported by a research grant from the division of hospital and medical facilities, Bureau of Medical Services, U.S. Public Health Service.

Table 1—Summary of space deficiencies in square feet in departmental areas of one hospital compared with minimum standards for a normal capacity of 32 beds.

Departments or Divisions	Actual areas	Standard areas	Surplus areas	Deficit areas
Administration	575	1,504	—	929
Laboratory	180	192	—	12
Radiology	435	512	—	77
Pharmacy	100	64	36	—
Nursing	3,995	5,555	—	1,560
Nursery	100	486	—	386
Surgical	370	1,376	—	1,006
Obstetrics	150	941	—	791
Emergency	0	410	—	410
Dietary	445	1,434	—	989
Central storage	405	800	—	395
Employees' facilities	45	640	—	595
Housekeeping and linen*	75	237	—	162
Mechanical facilities	185	928	—	743
Circulation spaces (corridors, stairways, elevators)	2,595	3,558	—	963
Total	9,655	18,637	36	9,018

*Excludes standard space for laundry because there is no laundry in this hospital.

ficiencies to the governing board, medical staff and architect. In addition, a summary table (see Table 1, p. 57), comparing the actual space in each department with minimum standards, can be used to explain modernization or construction needs to the community when fund raising is considered and to the state agency when Hill-Burton funds are being requested.

HOW METHOD IS USED

To determine hospital capacity by this method, it is necessary to measure all rooms or units of space in the hospital, assign each of these to its proper department and compare the total space for each department with standard space for that department in a hospital of similar size.

One of the authors (Lembcke) developed this method and has used it to determine the building needs of a large number of individual hospitals. We have used it in its present form to study all the hospitals in a 27-county general hospital service district as outlined in a state plan to see whether an objective index could be obtained for "replaceable" or "obsolescent" beds—i.e., beds without sufficient space, properly distributed, to meet the functional demands of modern hospital care.[1]

Use of this method in one hospital is shown in Table 1, which compares the actual departmental areas of one of the hospitals measured with the minimum standard areas described in this article. Every department but one showed deficient space, hence this is an example of a hospital found deficient as a whole. (Some hospitals are adequate as a whole.) We found, however, that use of this standard method disclosed some hospitals with deficiencies in patient rooms and others with deficiencies in diagnostic and treatment areas or in administrative and service areas.

HOSPITAL SPACE STANDARDS

The standard space for patient rooms in this article is based on the minimum of 100 square feet of open space for one-bed rooms, and 80 square feet per bed for multiple-bed rooms (private closets, lockers, toilets and showers excluded) required for hospitals constructed under the Hill-Burton Act.[2] The range in square feet per room by bed capacity is shown in Table 2.

Table 2—Maximum normal bed capacity per room, based on Hill-Burton program regulations*

No. of beds per room	Range in square feet
1	95 - 149
2	150 - 224
3	225 - 299
4	300 - 374
5	375 - 449
6	450 - 524
7	525 - 599
8	600 - ——

*Minimum of 100 square feet for 1-bed rooms and 80 square feet per bed for multiple-bed rooms.

Standard space allocations for each hospital department expressed in net square feet per bed for hospitals of different size classes are presented in Table 3, page 59. These standards are minimum and are based on standards first published in 1943[3] for hospitals built in the emergency defense program under the Lanham Act. These standards also appeared in 1947 and 1948 in a series of articles prepared by the hospital facilities section of the U.S. Public Health Service published as a magazine reprint.[4] Thus these standards are not new, and they need revision to meet changes in medical and nursing practice. However, because so many hospitals measured did not meet even these minimum standards in all departments, it seems reasonable to use them for judging existing structures until new standards are developed and accepted.

The method described can also be used with revised space standards. It is our hope that the use of these standards in the manner suggested here will arouse interest in the development of new space standards which can then be substituted for those in Table 3. Larger areas may be needed for patient rooms. For example, a Canadian standard issued in 1954 suggested 180 square feet for a one-bed room, 105 square feet per bed in two-bed rooms and 92 square feet per bed in four-bed wards.[5] If new space standards are developed for patient rooms, Table 2 can also be revised to include the new range in square feet per room.

STANDARDS BY HOSPITAL SIZE

Because standards developed by the U.S. Public Health Service[4] give figures only for hospitals of 25, 50, 100 and 200 beds, it was necessary to develop some method of finding the measured capacity of hospitals of intermediate sizes. This problem was discussed in an earlier article,[1] and it is perhaps enough to say here that we found that we could determine space needs for departments by using the midpoints between hospitals of given sizes to demarcate the size classes of hospitals to which a given number of square feet per bed applied. Thus, as can be seen in Table 3, an area of 627.9 square feet per bed suggested for a 50-bed hospital was assigned to hospitals of the 38 to 74 bed class. However, it should be noted that this method should not be used to derive standard square feet per bed for different units within a department.[1] Furthermore, hospitals with less than 25 beds pose special problems. In these very small institutions, it has been recommended that service departments should be no smaller than those for 25-bed hospitals.

The area distribution shown in Table 3 does not include the outpatient department, quarters for personnel, nursing school or other teaching areas, fuel storage, garage, or any other areas not specified in the department column. This table cannot be used, therefore, to estimate needs for modernization in respect to these items.

MEASURING THE HOSPITAL

The first step in measuring the hospital is to sketch a floor plan of each floor and record the dimensions and the name or function of each room or area on the sketch

(see Fig. 1, p. 60). Whenever possible, a blueprint can be traced to provide the outline of each floor and the rooms, but each room or area must be visited to note its current function and to measure it if there has been a change from the blueprint during building or in adapting the structure to use.

In hospitals for which no blueprints were available, we found it convenient to sketch the floor plan on grid paper divided in tenths, with one-tenth inch equaling one foot. Use of a civil engineering scale divided in tenths corresponding to this grid paper made it easy to draw a line at the proper place without having to count squares. (Or a small rule can be made by marking 2-foot and 5-foot intervals on a length of grid paper and enclosing it in a clear plastic index tab.)

Walls and partitions—Dimensions from wall to partition or wall to wall should also be recorded. Measurements in an existing structure will not be highly exact because of the difficulty in making allowances for radiators, ducts, columns and other design features. Hence, dimensions may be rounded to the nearest one-half foot. For example, a dimension measuring between 9 feet 9 inches and 10 feet 2 inches may be recorded as 10 feet, a tolerance of 5 per cent.

Except for small areas such as closets and toilets, where a ruler was used, most of our measurements were made with a measuring wheel device—because we found this easier to manage than a tape measure. However, it is efficient to have two people work together even when the measuring wheel is used.

Measurement of rooms for patients—The length and breadth of patient rooms should be measured and recorded so that the open space in the room can be calculated separately from the areas for closets, lockers, toilets and bathrooms that are a part of the room. For example, in the room in the upper right hand corner of Figure 1, the open space is 12 by 17 ft. plus 4 by 2 ft. or a total of 212 sq. ft. The bath is 4 by 5 ft. (20 sq. ft.) and the closet or locker is 4 by 1.5 ft. (6 sq. ft.). This procedure is necessary because the standard used for determining normal bed capacity is based on the open space in patient rooms.

DEPARTMENTAL AREA CALCULATING

When the sketch of each floor plan has been completed, the dimensions of each room or unit of space should be entered on a work sheet or form so that unit areas can be calculated and added to obtain the total departmental areas.

A guide for assigning rooms or areas to their proper departments

Table 3—Area distribution in net square feet per bed for departments of general hospitals.

Departments or divisions	Normal Bed Capacity				
	25 to 37 beds	38 to 74 beds	75 to 124 beds	125 to 174 beds	more than 175 beds
Administration	47.0	39.4	29.8	23.8	23.9
Laboratory	6.0	5.6	6.4	6.3	5.6
Morgue	—	5.6	5.0	3.3	2.5
Radiology	16.0	11.3	5.6	7.2	6.4
X-ray therapy	—	—	—	—	8.8
Physical therapy	—	10.4	8.2	6.8	6.1
Occupational therapy	—	—	—	2.7	2.5
Pharmacy	2.0	4.1	4.1	4.0	3.6
Nursing	173.6	176.1	180.0	180.0	180.0
Nursery	15.2	10.0	8.4	8.0	8.2
Surgical	43.0	39.6	31.0	28.1	25.2
Obstetrics	29.4	23.5	15.0	12.7	10.6
Emergency	12.8	7.4	3.7	3.4	3.9
Dietary	44.8	48.0	30.7	25.1	25.2
Central storage	25.0	23.5	22.4	22.2	22.0
Employees' facilities	20.0	15.3	12.2	10.6	9.5
Housekeeping and linen	7.4	8.6	5.8	4.2	3.5
Laundry	4.6	18.7	12.2	11.3	10.1
Mechanical facilities	29.0	20.6	14.8	12.0	9.8
Circulation spaces (corridors, stairways, elevators)	111.2	160.2	137.1	135.2	134.4
Total	587.0	627.9	532.4	507.0	501.6

Note: Areas do not include walls and partitions. Bed capacities are based on adult and child beds only. Space for bassinets is included in the nursery, but these bassinets are not counted as beds. The areas do not include the outpatient department, quarters for personnel, nursing school of any other teaching area, fuel storage, garage, or any other area not specified in the department column. For a detailed description of units within the departments by size of hospital, see reference 4.

Source: The five columns correspond with the data summarized (see reference 4) for hospitals of 25, 50, 100, 150 and 200 beds, respectively, with the following modifications: (a) a formula room of 255 square feet has been included in the 50-bed hospital dietary facilities as the omission of any formula room in a hospital of this size was apparently an error; (b) small errors in addition or rounding have been corrected.

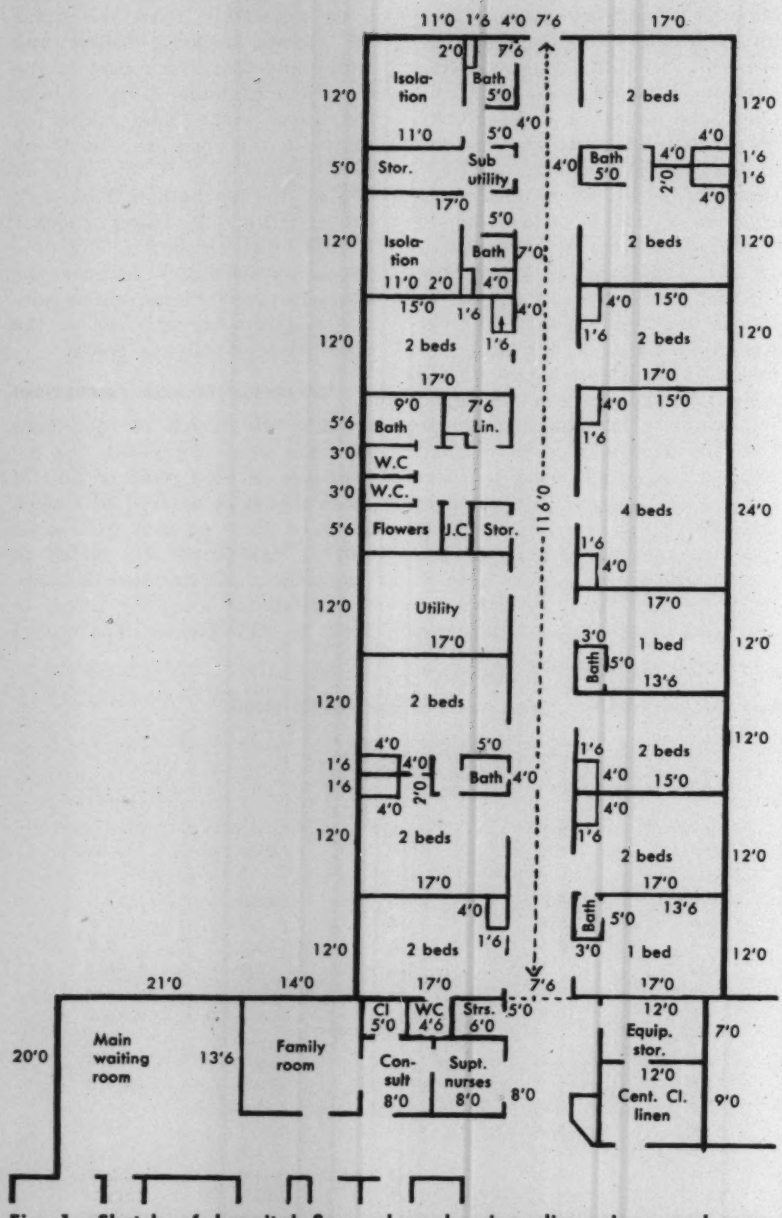

Fig. 1—Sketch of hospital floor plan showing dimensions and room functions

may be obtained by using a list of departmental units (see box, p. 61).

The work sheets will be quite long—especially in larger hospitals—because so many units must be entered under almost every heading. For example, under circulation spaces we found that it often required several pages to enter the dimensions of each of the halls and passages that had to be added to obtain the total area for corridors.

An example of the work form for the surgical department is shown in Figure 2, page 62.

If typed work forms are to be prepared for measurement of a number of hospitals—as by a hospital planning council or the hospital agency of a state health department—a separate page for each department unit may be set up. Thus continuation sheets can be conveniently inserted if they are necessary.

Bed area in the nursing department—A special form should be used to calculate the area in the nursing department (see Work Form B, Fig. 3, p. 62). The total for column 9 (bed room area—including the closets, lockers and private toilets in column 8 plus the open space available for care of the patients in column 4) can then be entered under "bed area" on the nursing department work form.

USE OF SPACE STANDARDS

The next step is to compare the space in patient rooms with the standards. From this step, the normal bed capacity of the hospital will be found. The last step is to compare total space in each department with standard space for each department in a hospital of similar normal bed capacity.

Patient rooms—Although the space standards for patient rooms is 100 sq. ft. of open space for one-bed rooms and 80 sq. ft. per bed for multiple-bed rooms (private closets, lockers, toilets and showers excluded),[2] deviations of 5 sq. ft. per bed below the minimum are permitted because the measurements carried out in existing structures are not highly exact. Hence, the space standards are expressed in a range of square feet per room by bed capacity. (See Table 2, p. 58.)

Normal bed capacity—Normal bed capacity, a term first used in 1946 by the Commission on Hospital Care[6], is determined not only by the space standards in Table 2 but by the number of hospital beds appropriate for patient rooms as the result of the intention of the designer. For example, a one-bed room may have an area as great as the minimum described for a two-bed room, but if it was designed for the isolation of a mental patient, the location of toilet, lavatory and closet, or the inclusion of double doors may prevent the accommodation of two beds without a dangerous or inefficient degree of crowding. Similar instances may be encountered in multiple-bed rooms.

Therefore, whenever the design capacity is less than the minimum space requirement, the design capacity should determine the normal bed capacity. (See the ex-

DEPARTMENTAL UNITS FOR GENERAL HOSPITALS*

A guide for assigning rooms and areas to the proper department

Administration department

1. Administration
   - a. Main lobby and waiting room
   - b. Retiring room
   - c. Public toilets
   - d. Public telephone(s)
   - e. Admitting office
   - f. Social service
   - g. Information and telephone
   - h. Administrator
   - i. Secretary
   - j. Business office(s)
   - k. Personnel toilets
   - l. Record room
   - m. Director of nursing
   - n. Assistant director of nursing
   - o. Staff lounge library and conference room

Adjunct diagnostic and treatment facilities

2. Pathology
   - a. Laboratory
   - b. BMR, EKG, and specimen room
   - c. Office
   - d. Morgue
3. Radiology
4. X-ray therapy
5. Physical therapy
6. Occupational therapy
7. Pharmacy (bulk stores included in central stores area)
   - a. Solution
   - b. Pharmacy
   - c. Manufacturing

Nursing department

8. Patient areas (nursing units)
   - a. Bed area (includes room, clothes, lockers and private room toilets and baths)
   - b. Treatment rooms
   - c. Solaria
   - d. Visitors
   - e. Nurses' stations
   - f. Toilets, baths, bedpans
   - g. Utility rooms
   - h. Subutility rooms
   - i. Floor pantries (central tray service used)
   - j. Closets (stretcher, linen, storage, janitor)
   - k. Flower rooms

Nursery

9. Nursery (formula room included in dietary area)
   - a. Nursery
   - b. Premature nursery
   - c. Work space and examining space
   - d. Suspect nursery
   - e. Suspect anteroom

Surgical department

10. Surgical
    - a. Major operating rooms
    - b. Minor operating rooms
    - c. Cystoscopic room
    - d. Scrub-up alcove
    - e. Substerilizing room(s)
    - f. Central sterilizing and supply
    - g. Unsterile supply room
    - h. Instruments
    - i. Clean-up room
    - j. Storage closet
    - k. Stretcher space
    - l. Janitor's closet
    - m. Surgical supervisor
    - n. Recorder
    - o. Physicians' locker room

Surgical department (continued)

- p. Nurses' locker room
- q. Fracture room
  - (1) Plaster closet
  - (2) Splint closet
- r. Darkroom (x-ray)
- s. Anesthesia storage

Obstetrics department

11. Obstetrics
    - a. Delivery room(s)
    - b. Labor room(s)
    - c. Scrub-up alcove
    - d. Substerilizing
    - e. Clean-up room
    - f. Physicians' lounge
    - g. Nurses' lounge
    - h. Nurses' station
    - i. Nonsterile storage
    - j. Sterile storage
    - k. Stretcher storage
    - l. Janitor's closet

Emergency department

12. Emergency
    - a. Emergency operating room
    - b. Office and waiting room
    - c. Bath
    - d. Toilet
    - e. Utility room
    - f. Storage and supply closet
    - g. Stretcher and wheel chair closet
    - h. Observation beds

Service department

13. Dietary facilities (designed for central tray service)
    - a. Main kitchen and bakery
    - b. Diet kitchen and dietitian's office
    - c. Formula room
    - d. Dishwashing and truck washing
    - e. Refrigeration
      - (1) Meat
      - (2) Diary products
      - (3) Fruit and vegetable
    - f. Garbage and can washing
    - g. Day storage
    - h. Dining space, including serving space. Staff supervisory, employees and nurses, (two sittings)
    - i. Employees (two sittings)
14. Housekeeping facilities
    - a. Central linen room, sewing room and housekeeper's office
    - b. Soiled linen
    - c. Laundry
15. Mechanical facilities (no fuel storage space included)
    - a. Boiler and pump room
    - b. Engineer's office
    - c. Maintenance shop(s)
16. Employees' facilities
    - a. Nurses' locker room (including lockers, toilets, shower and rest space)
    - b. Male help's locker room (including lockers, toilets, shower and rest space)
    - c. Female help's locker room (including lockers, toilets, shower and rest space)
17. Storage
    - a. Record
    - b. Central stores

Circulation spaces

18. Circulation spaces
    - a. Corridors
    - b. Stairways
    - c. Elevators

*Prepared by the U.S. Public Health Service

Fig. 2—Work Form A—Departmental units or areas in net square feet.

(1)	(2)	(3)	(4)	(5)
Departments or areas	Length	Depth	Square feet (2)x(3)	Notes
Surgical department				
Major operating rooms				
No. 1	17'6	18'6	324	
No. 2	17'9	18'6	328	
No. 3	17'9	18'6	328	
No. 4	17'6	18'6	324	
Central sterilizing and supply	45'6	17'6	796	
Substerilizing	10'6	10'0	105	
Scrub room	10'6	8'0	84	
Fracture room	15'6	18'6	287	
Total				

ample on Work Form B, where Room 101 has space enough for five beds, but has a normal bed capacity of four.) If the design capacity of the room is not known, and no blueprint can be found, valuable clues can be obtained from the location of electric outlets, nurse's call system, etc.

In general, the space requirements will be found to apply. The normal bed capacity of each room can be calculated—except in the above instance—by applying the range in square feet shown in Table 2 to the open space area in each room in column 4 of Work Form B. The number of beds allowed by the standard space (or by the design capacity if this is a smaller number of beds) should be entered in column 5. The sum of these room capacities is the hospital's normal bed capacity.

Bed complement figures—Bed complement figures refer to the number of beds set up and ready for use at any given time, regardless of the floor space allotted to them. These figures do not indicate the normal safe and efficient working capacity of a hospital.

The difference between a hospital's normal bed capacity and its bed complement is one measure of the adequacy of the bed areas and, therefore, one index of the need for modernization of that part of the hospital. Because modern medical and nursing care call for sufficient space around the bed to permit many procedures to be carried out in the patient's room, a nursing department with rooms lacking space to carry out such

Fig. 3—Work Form B—Patient rooms in square feet* (excluding newborn nursery).

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	Open Space								
Room no.	Length	Depth	Area in sq. ft. (2)x(3)	Normal bed capacity	Design capacity	Bed complement (number beds set up today)	Closets, lockers, private toilets	Total bed room area (4)-(8)	(Notes)
100	16'6	12'0	198	2	2	2	4'0x1'6 = 6'0 3'0x5'0 = 15'0 21'0	219	
101	18'0 15'0	12'0 12'0	396	4**	4	5	----	396	
etc.									
Total									

*Areas and dimensions do not include walls and partitions.
**The design of the room and not the space makes four rather than five the normal bed capacity.

procedures safely and efficiently can be regarded as needing modernization.

Departmental space for normal bed capacity—Table 3 shows standard space allocations for each department expressed in net square feet per bed for hospitals with normal bed capacity of different size classes.

To determine the standard area for a department in a given hospital, the square feet per bed for the size class in which the hospital falls—after its normal bed capacity has been found—is multiplied by its normal bed capacity (the total number of beds in column 5 of Work Form B). For example, if the hospital has 112 beds as its total normal bed capacity, the 29.8 sq. ft. per bed which is the minimum standard for administration in hospitals with a normal bed capacity of from 75 to 124 beds would be multiplied by 100 to obtain the standard area for that department. The final step in the method is to compare the standard area with the actual space in each department as recorded in Work Form A and to determine the deficit areas.

A summary work table for listing the actual areas in each department of the hospital, for calculating the standard departmental areas for a hospital of similar normal bed capacity and for obtaining the deficit areas by departments, is shown in Work Form C (see Fig. 4). The deficits shown in column 4 of Work Form C represent the additional space needed by each department to meet the standard.

Surplus space—The Commission on Hospital Care used the term "potential bed capacity" for areas of the hospital currently used for other purposes but intended for the eventual accommodation of patients as the need for hospital beds increases. For example, student nurses might be housed for a time in a division of the hospital designed for conversion to a nursing unit for patients.

Because the standard areas used in this method for determining space needs for modernization are minimum figures, surplus space in one department of the hospital should not be counted as offsetting

(Continued on page 132)

Fig. 4—Work Form C—Standard hospital measurement summary for normal bed capacity.

Hospital _____

Normal bed capacity _____ Acceptable beds, stage plan _____

Actual beds on survey day _____ Nonacceptable beds, stage plan _____

Areas in net square feet

	(1)	(2)	(3)	(4)	(5)
		Standard space			
Departmental areas	Actual	Per bed*	Area (2) x normal bed capacity	Deficit space (3)-(1)	Notes
Administration department					
Adjunct diagnostic and treatment facilities:					
Pathology					
Radiology					
X-ray therapy					
Physical therapy					
Occupational therapy					
Pharmacy					
Nursing department					
Nursery					
Surgical department					
Obstetrics department					
Emergency department					
Service department:					
Dietary facilities					
Central storage					
Employees' facilities					
Housekeeping					
Laundry					
Mechanical facilities					
Circulation spaces					
Total area included in standard					

*See Table 3. Enter the standards for the size group of the hospital's normal bed capacity.

OPEN-STAFF POLICY OPENS THE DOOR TO IMPROVED PSYCHIATRIC THERAPY

by MORRIS B. SQUIRE

An open-staff policy in a psychiatric hospital, according to the author, contributes to better patient care, to community education about mental health and illness and to more effective psychiatric therapy. In this article, he describes four years of experience with an open-staff policy in a private psychiatric hospital in the suburban area of a large metropolitan center.

PSYCHIATRY today stands at the threshold of a new era of public enlightenment. Everywhere there is evidence that the American public is changing its attitudes toward mental health. In Forest Hospital's community (Des Plaines, Ill.), we have discovered that people are eager for information, that they wish to understand. They have begun to see that mental health and mental illness enters into every thread of the fabric of their lives. It seems evident that the public is beginning to understand what hospital and medical personnel have known for a long time: that mental health is not a birthright of "good" people and that no one is immune to emotional crises and mental illness.

Because of our location in a suburban area of Chicago, we at Forest Hospital may be in a position to observe this growing phenomenon of enlightenment with greater clarity than more crowded and busy surroundings would permit. But it is there, and the changes it is bringing about already are evident.

This can be seen in the lively, interested response from members of a men's service club, for example, to a talk on mental health, or in the responsive attitudes of patients and their families. The willingness of local newspaper editors to print long stories on mental health is a sure sign of general interest in the topic. An almost tangible lessening of the age-old fear of the mentally ill is a part of this change. These and many other signs —not the least of which is the quickened interest in mental health among physicians who are not psychiatrists—indicate that psychiatry's future, in terms of its relationship to the rest of society, is brightening steadily.

Morris B. Squire is administrator of Forest Hospital, Des Plaines, Ill.

HOPE IS THE KEY

But one effect of this increased public understanding is bound to be an increased demand for psychiatric service. More people will want help, and will want it early. They will seek counseling, group therapy, medication, and hospitalization just as soon as it is clearly understood that the problems of mental illness can be *improved*. Stigma or not (and the stigma of mental illness is losing its grip), people will look for help if they believe they can get better. This new hope is the key to changing public attitudes.

In the face of a growing demand for service, however, psychiatric resources are in short supply; not just short in terms of future needs, but already short in terms of present needs. Approximately 12,000 additional psychiatrists are needed. The field is short of beds; patient stays are long. There is a shortage of foster homes, psychiatric nurses, psychiatric social workers, group therapists, occupational therapists and recreational therapists. Research activity is limited and funds to support more research are lacking.

Help, of course, will come. The public will pay for the things it really wants, and in the not-too-distant future, public funds for psychiatric research, for training psychiatric personnel and for building *needed* facilities will be much easier to get. In fact, in some instances, as is now the case in cancer research, funds will be appropriated whether or not the people exist who can use such funds.

In the meantime, we who are involved professionally must look for ways in which psychiatry can cope

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with the problem of shortages all along the line. A great deal already is being done. Without the massive backing of government departments or foundations, psychiatry is making headway in public education, in recruitment, and in relationships between the profession and related disciplines.

THE OPEN-STAFF POLICY

One notable advance made by a handful of private psychiatric hospitals is of especial interest. This is the development of the open-staff policy. By this step, the record shows, existing facilities can be made more useful to more people, and psychiatry can render far greater service to the community.

The open-staff policy as carried out at Forest Hospital is one which permits *any* qualified physician to admit a patient to the hospital. This includes nonpsychiatrists as well as psychiatrists. However, nonpsychiatrists who admit patients to Forest Hospital relinquish psychiatric management of the patient. They may, if they wish, retain medical management during the patients' stays in hospital.

Although the open-staff policy has presented many problems, it has had striking results. It has worked to make Forest Hospital a better hospital and has greatly improved patient care. The problems of an open-staff policy will be obvious to any hospital administrator. They are the problems imposed by variety.

In the past, most private psychiatric hospitals were dominated by a single therapeutic philosophy; if not, indeed, by a single personality. Such institutions were not eclectic and usually were poorly suited to short-term, acute "crises" treatment, apart from shock therapy. However, these closed staff hospitals were easier to operate. Staff personnel could be trained readily and physician relationships were easier to keep on an even keel. This was accomplished by shunning the outside professional world, the broad community of medicine. There was, accordingly, closer control of patients because each patient was treated as were all the others. A routine was established; everyone—physicians, patients and staff—conformed to it.

The open-staff hospital, by abandoning this way of operating, brought upon itself all the problems that this restrictive policy automatically solved. In an open-staff hospital, personnel are more difficult to train and patients are more difficult to handle because the hospital must "fit the patient", rather than the other way around. And, of course, treatment philosophies must always remain diverse, simply because the hospital is being used by psychiatrists with many points of view.

OPEN-STAFF STRENGTHS

But overcoming these problems constitutes the strength of the open-staff hospital, which becomes a facility at which more patients may be treated, where patients get better care and where physicians benefit from the diversity of opinion they find around them.

Forest Hospital is a 90-bed institution serving 72 physicians. The hospital is oriented toward short-term, intensive therapy and puts at the disposal of the attending staff all available techniques of therapy. Average patient stay is about three weeks. Forest Hospital admits as many patients in the course of a year as do a number of state hospitals in Illinois—all of them with 20 times Forest Hospital's bed capacity. Patients come largely, but by no means exclusively, from the large, rapidly expanding suburban area in which the hospital is located.

To handle the needs imposed by the open-staff policy, Forest Hospital has had to train all hospital personnel with exceptional care. Regular classes have been conducted. Indoctrination is constant, and includes not only nurses, but therapists, attendants and office and maintenance personnel. Every effort must be made to prevent routine handling of the patient. The result has been the creation of a personnel group of exceptional calibre.

CARE STANDARDS PROTECTED

The quality of patient care has been improved by the measures taken to offset any drop in quality that may have taken place in the absence of a single dominating personality. The first move was to insist that physicians admitting patients to Forest Hospital be highly qualified, even if they were to have only courtesy privileges.

The second step was to establish a superior house staff to act in consulting and supervisory capacities. Including the house staff, nearly every patient at Forest Hospital actually is kept in contact with two psychiatrists, although the attending man is clearly in charge of therapy.

In addition, monthly clinical conferences, attended by a majority of staff, have made possible a broader view of treatment and new insights into difficult cases. Regular round tables, with from five to 30 psychiatrists in attendance, give physicians the opportunity to ask for new therapeutic directions in difficult cases. In these ways, the diversification of viewpoints among staff has been put to work to provide better patient care.

HANDLING CRISES PERIODS

One effect of the open-staff policy has been particularly gratifying. Analytically oriented psychiatrists, chairbound in the past and unwilling to interrupt therapy to admit patients to hospitals, have begun to use Forest Hospital's facilities to ease their patients through crises periods. These physicians retain the psychiatrist-patient relationship throughout the period of hospitalization and continue outpatient treatment after hospitalization with no hiatus. Other psychiatrists, too, have taken advantage of this policy by admitting patients when outpatient care was not feasible, then returning them to outpatient care at the earliest opportunity.

This ability to maintain treatment continuity in and out of hospital has been a major reason for the shorter average patient stay at Forest Hospital. This shorter stay, stemming from the new policy, has benefited patients in many ways. Family life has suffered fewer disruptions; earning capacity has improved, and most of all, greater hope has been instilled in patients who find they are not incapacitated for months, or even years, at a time. And families and friends learn indirectly that mental illness requiring hospitalization does not necessarily mean the end of existence. This builds hope and greater under-

standing in the whole community.

The administration of Forest Hospital has benefited from the open-staff policy by being brought under the constant scrutiny of a large group of physicians. This scrutiny has prevented the development of any smugness or ingroup complacency. Many constructive suggestions from the large attending staff have been received and carried out. Patient care also has been improved through this constant scrutiny.

Relationships with the community and with other hospitals have been improved. The greater number of physician contacts has helped to produce greater community understanding. Liaison with other hospitals has improved because attending psychiatrists have exercised their best judgments in assessing patients as regards hospitalization.

The open-staff policy has been in effect at Forest Hospital for four years. It has enabled the hospital to give more patients better care and to meet the needs of a far greater number of psychiatrists. The policy has enabled the hospital to be a far more vital force in the community and, therefore, to serve the community much better.

Any psychiatric hospital willing to reorient its personnel to serve more than one master—that is, to treat patients according to the diverse points of view of a large number of psychiatrists—can render ever greater community service by adopting the open-staff policy. ■

NOTES AND COMMENT

Realistic x-ray barrier requirements

Measurements made by the National Bureau of Standards, in a program sponsored by the Atomic Energy Commission, indicate that present methods of determining barrier requirements for x-ray installations may result in walls with protective barriers that are several half-value layers thicker than actually required.

The usual procedure for calculating required barrier thickness is to assume near-maximum values for the various factors—work load, exposure time, effect of coning, attenuation of patient—affecting the exposure of the barriers if more precise knowledge of them is not known. In actual practice, one or more of these factors may be considerably less than the maximum values assumed for busy installations, and the barrier thickness required for personnel protection may thus be less than that indicated by the calculations based on these assumptions.

In this study, the amount of radiation reaching various regions of the x-ray rooms was determined through the use of pocket-type ionization chambers. As many as 70 of these instruments were attached to selected positions on the ceiling and walls of each room. Readings were taken once or twice a week, depending on the exposure, during a period of one to two months. The penetrating quality of the radiation was determined from attenuation curves obtained from readings of instruments that were surrounded with varying thicknesses of aluminum or lead.

The work load in milliampere-minutes of each installation was automatically determined by a charge-integrating device connected to the x-ray control. From the data obtained, it seems reasonable to assume, when no specific information is available, a work load of 1000 ma-min per week for a busy diagnostic x-ray room.

The amounts of lead shielding required to reduce exposure to the desired level were calculated from the collected data for those rooms having maximum exposure and use. These thicknesses were generally considerably lower than values arrived at using the usual procedure, indicating substantial safety factors.

The results of this study may eventually result in a reduction in the amount of shielding needed for x-ray rooms by use of more realistic values used in computing the barriers. ■

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purchasing

MANAGEMENT-ORIENTED PURCHASING

by W. R. WILLIAMS

Since purchasing is a management function of the hospital, according to the author, the purchasing agent should learn to use management tools efficiently and effectively. The author also stresses the need for a sound management policy to guide the purchasing agent in the proper performance of his function.

PURCHASING can be defined as a centralized function charged with the responsibility of buying the quality of goods and materials needed at the right time in the right quantity and at the best price available for the entire hospital; not just for the storeroom or the housekeeping department, but for the entire institution. This definition clearly places a management responsibility upon the purchasing agent, or department, or division. A concomitant degree of authority should be placed alongside the responsibility. In no hospital can any person long meet and execute his responsibilities without a precisely equal degree of authority. It is time that hospitals stopped asking the purchasing agent to do the impossible. In some institutions a great deal of authority rests with the purchasing agent, but others operate with a purchasing agent in name only. The result is a hodgepodge of decentralized order placing by a half dozen or more departments and the major responsibility of the purchasing department is to issue confirming orders—when it can—and to hope to be able to learn enough about the transactions to recognize the invoices when they arrive.

INFLUENCE OR INTEGRITY

A position of management responsibility and authority for the purchasing function in hospitals cannot be claimed if undue influence by members of boards of trustees or officers of women's auxiliaries is allowed to sway buyers' judgments. Friendship is entitled only to a small vote in the purchasing transaction; ethics and integrity are much better guidelines. It may be that the administrators, in some cases, should provide a heavier layer of insulation between influential board members and purchasing agents. Purchasing could be a more effective tool of management if it did not have to compete or contend with "friendly words" and comments from third parties in the purchasing function. Unless purchasing is an assigned responsibility of the administrator, he, too, might well refrain from exercising undue influence on selection of sources of supply.

The efficiency and importance of sound purchasing, as a management tool, are in direct ratio to the size and scope of the purchases made. One can certainly hear and understand the argument, however, that regardless of volumes concerned, the methods of acquisition of things by a hospital directly reflects the efficiency of its total management. This leaves no choice but to consider and treat purchasing as a stone somewhere near the keystone of the arch of hospital management. All parts of any foundation must be dependable; certainly, this part of the hospital foundation must evidence a high degree of integrity and effectiveness.

Let's look for a moment at how this management-oriented purchasing department should function. First, the organizational structure should clearly indicate the status of purchasing. In a large hospital —500 beds or more—an assistant administrator in charge of purchasing, stores and property is not out of order. He will have plenty to do. Certainly, purchasing must be centralized under one head; it would be most difficult to operate any hospital without centralization of both purchasing and personnel functions. In operations of smaller size, whenever justification can be made at all for a purchasing department, the purchasing agent should rank at the level of the other department heads. His is an interdepartmental activity as well as intradepartmental, and he must be assigned a staff of assistants commensurate with the existing volume of activity and the degree of participation desired.

DEPARTMENT RESPONSIBILITIES

This department should be assigned the operation of any central stores activities and all consumable or permanent property inventory control. Receiving and shipping are certainly responsibilities. One may go a bit further—with excellent results—and place any printing and central mailing activities in this department's charge.

The person in charge of these areas of operation, even though he may constitute the entire purchasing staff, should report directly to the administrator. This close re-

W. R. Williams is administrator of The Suburban Cook County Tuberculosis Sanitarium, Hinsdale, Ill. This paper is based on a presentation at an American Hospital Association Institute on Hospital Purchasing.

porting relationship does not imply a constant "look over the shoulder" any more than with the dietitian or director of nursing. It is simply to ensure open channels of communication and inquiry in the best interests of hospital coordination and management. Purchasing is rather more of a science than an art, but there are some complex problems of specifications, contract and decision which arise daily, and free discussion can assist considerably in arriving at the decision which maximizes the hospital's interests. It is not unthinkable, too, to expect differences of opinion between purchasing agents and other department heads to arise, which might require a little arbitration between the interested parties by the administrator.

As a member of the top management team, the purchasing agent can make a valuable contribution, too, to any forward planning of operations, budgeting and, perhaps, even to the study of rate and charge schedules. After all, he should be in possession of the most detailed information concerning commodity costs and trends in price, delivery and availability.

MANAGEMENT POLICY

A management policy which should be given to the purchasing agent for his guidance, is a statement of the attitude of the hospital toward future buying. A hospital purchasing agent should not assume a responsibility of this nature unless he is clearly instructed as to the expected scope and extent of this practice. In the face of an attractive present price, and an almost certain future price increase, many purchasing agents are tempted to overload inventories of constantly used materials. This can be embarrassing if the storage of this bargain crowds already scarce storage areas; it can be embarrassing if unforeseen deterioration or decreasing demand ensues, and it can be a very touchy spot if the hospital doesn't have the funds to finance such purchases. Some hospitals are notoriously slow in the matter of accounts payable; compounding this problem by overloading, even when acting with the best of intentions, is not in the best management interest. Good purchasing can be of a great deal of assistance in promulgating patterns to be followed in this area of policy.

SPECIFIC PROCEDURES

This leads to a subject of the greatest importance, but which is too often neglected. That is the development of a specific set of purchasing procedures which covers the policy, mechanics and responsibilities of the purchasing function, and which bears the approval of the governing board and which is made known, in writing to the entire hospital family. Such a procedure is almost a *sine qua non* to good purchasing and does a great deal to improve understanding between department heads and management. It is also very helpful in dealing with individual suppliers who might wish to see a bit more informality enter into the purchase routine.

Every purchase contract has a legal involvement both for vendor and vendee, so it should be based on a prior, reasoned set of rules

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FOOD SERVICE EQUIPMENT

and procedures on the part of the hospital. It is reasonably certain that the seller is basing his actions on a clearly defined set of rules. This "purchasing bible" need not be a formidable and detailed document, but it must be extensive and inclusive enough to leave no doubt in the reader's mind as to where, when and how the buying takes place in a particular institution. Like any other set of operating procedures in the hospital, purchasing procedure may be subject to necessary changes, but it should be changed only after full thought and discussion, and then, all parties interested in the approved changes should be apprised. Again, the coordination of purchasing know-how and management objectives and policy are essential to the development and implementation of this administrative guide.

In the matter of operating the purchasing department to insure optimum effectiveness, there are a few mechanics that cannot be ignored if one is to get the greatest possible effectiveness from purchasing. There is, of necessity, a great deal of correspondence involved in any volume purchasing operation. It goes without saying that purchase inquiries, bids, quotation requests, purchase orders, etc., must emanate from the purchasing office. But, in addition, there are such things as damage claims, returns and exchanges, expiration datings on some drugs and chemicals, and certifications of warranties and guarantees. The correspondence incidental to all such items should be the sole responsibility of purchasing. Centralization of such matters makes for speedier and more efficient resolution of these problems. The purchasing department must keep other departments informed of many of these affairs, so a copy of such pertinent correspondence should go to all interested parties. But the individual departments should not be allowed to develop the habit of negotiating such matters, or the purchasing department will waste a great deal of time keeping up with and straightening out the inevitable confusion.

An alert purchasing department may, where feasible, try to buy cooperatively with neighboring or related institutions. Group purchasing of some commodities can afford distinct savings. The many facets of this sort of transaction must be handled by specific management policy. Such policy can well be formulated only after an intelligent purchasing survey of the possibilities. A purchasing advantage being used more and more today is the combining of a few nonfair trade items on the same bid list with fair trade items. Suppliers are rightly reluctant to violate policed fair trade agreements, but frequently are quite willing to lengthen normal discounts on noncovered material. It has been my observation that a great deal of true competition has been eliminated by pricing practices currently in vogue in the hospital supply field. Competitive pricing still exists with enough items and lines, however, to justify the continued search for the better price. Such items as quality of service, delivery time and instructional services and materials may frequently represent the only advantage available to the buyer.

The rather onerous and time-consuming job of preparing detailed specifications has been lightened considerably in recent years by the rather widely accepted practice of buying by brand name or equal. However, the need frequently arises for a custom-written specification for something the hospital needs. Generally, the specification written determines the price to be paid. Thorough discussion by all interested parties will help to arrive at a mutually understood and accepted specification when this need arises.

One of the matters of concern to purchasing, particularly in not-for-profit corporations, is the maximum amount of allowable expenditure that may be made for one item or commodity without prior approval by administration or the governing board. Such dollar limitation is not a reflection on the ability or integrity of the purchasing agent, and if reasonably set, does not normally impose unbearable restrictions; it can rather act as a thought-provoker or pause for further consideration before making major commitments.

Another major contribution which purchasing can make is in the matter of salesmen—who shall see them, when and how? Good relationships with salesmen are an absolute necessity to a successful purchasing technique, but, all too frequently, such a relationship is lacking. Salesmen should be treated courteously at all times, for they are not only trying to make a living as purchasing agents are, but also they can be a valuable source of information. A schedule of hours in which salesmen will be seen can be established, but it should not be inflexible. Each salesman should be told whether or not he may discuss his product with department heads other than the purchasing department. A purchasing agent cannot effectively prohibit this interchange of information unless he wishes to become an awfully busy middle man between equally busy people. A simple but enforced understanding that communication may exist on a prearranged basis with any legitimately interested member of the hospital family and the salesman—but with no commitment to be made by anyone outside the purchasing office—seems to work under most circumstances. Few purchasing agents are well versed enough on every use of every product in a hospital to make every decision relative to its acquisition. Few "smart" purchasing agents try to go it completely alone in this area, for an intelligent review and study of new items alone would take a tremendous amount of one's time.

PURCHASING RESEARCH

Whether other hospital personnel are aware of it or not, an active purchasing department conducts a good deal of research in a year. This research may be product testing, equipment development or modification, use surveys and other activities. In product testing, every department should constantly maintain an open mind in respect to new materials and supplies. It is true that such a constant program absorbs a lot of time and does cost money. The purchasing agent, however, can be selective to a degree on *what* he tests, *when* he tests and, if he is careful to offer to pay for his testing samples, *how* he tests. The glowing

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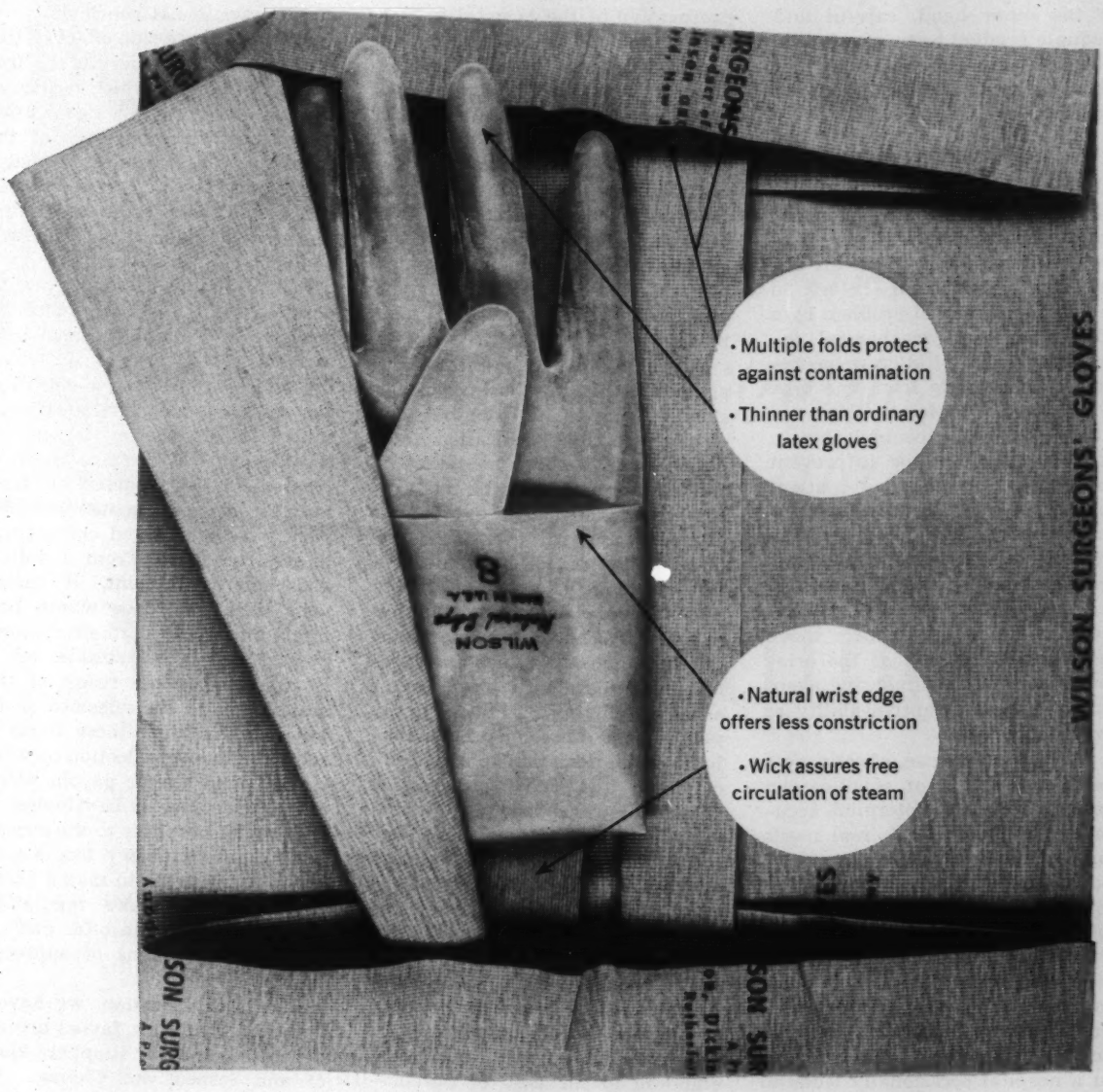
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terms in which many new materials are described may be less factual than enthusiastic, which is all the more reason for hospitals in many cases to satisfy themselves about the merits of the products. On the other hand, careful and adequate product testing can often determine the one best item for a hospital from a host of proffered products.

EQUIPMENT MODIFICATION

In respect to equipment modification, every purchasing agent has at one time or another—perhaps with some help from his engineering department—solved a vexing departmental problem by a little study and mechanical ingenuity. Our hospital crew has removed basin rings from one type of cart and replaced them on others. When we couldn't buy a suitable chart detainer to prevent unauthorized review of patient charts, our staff designed and installed them. We may have infringed upon a patent, but our crew has developed and made several very effective sets of bed-moving equipment which move beds around as well as the original casters. The purchasing agent should use his adaptive ability at every opportunity.

Surveys of the use, effectiveness and consumption of supplies can do a great deal to determine accurately the institution's real needs and optimum purchase quantities. Such studies can frequently lead to time and quantity contracts which effect considerable savings. Purchasing should be able to recommend intelligently such commitments to management in many areas. The true picture of what actually happens to the supplies in a hospital occasionally leads to substitution of a more effective and fitting product. A purchasing standards committee is a management adjunct that the purchasing agent can well use. The functions of a standards committee in a hospital may be either formal or informal. The larger the institution, the more formal the activity. An alert purchasing department should guide and direct all of the deliberations of such a committee, objectively and with the disclosure of all pertinent information.

Remodeling and expansion activities of hospitals provide many service opportunities for good purchasing departments. Obviously, few contractors will be interested in a hospital purchasing bricks, lumber, or concrete, but it is a prerogative of the hospital to buy any equipment being installed in such operations if this intent is written into the specifications. Some equipment can be obtained by the hospital directly at better prices than those at which the contractor will deliver the same items. Kitchen equipment, laundry equipment and some laboratory equipment are common examples of items where a little forethought and purchasing advice can save money.

As a vital part of hospital management, the purchasing officer should bring to his job the necessary training, education and background to carry his share of the load, or he should be ready to correct any deficiencies in this area as quickly as possible. Nearly every metropolitan or college center offers academic courses to supplement previous education and job experience. There are professional purchasing groups which exist primarily to upgrade the professional aspects of buying. Field trips to the plants which make or process major hospital items can be most educational, and most progressive firms will welcome a visit, without the expressed or implied element of reciprocity. An open mind and a strong back are two of the most important prerequisites to the making of a good purchasing agent. It would not be amiss to mention that a speaking acquaintance with business law—contracts, agency and tort—can frequently avoid embarrassment and misunderstanding in the field of purchasing.

COMMERCIAL BRIBERY

Another area of purchasing that deserves a critical eye and certainly the purchasing agent's best executive judgment is that of commercial bribery—perhaps better known currently as "payola" or "kumsha". This deterrent to efficiency takes many forms and it exists in some hospitals. It is a matter of degree in many cases. The acceptance of a free lunch or a desk pen may not and certainly *should* not, influence judgment in matters of purchase. The acceptance of a free vacation might also have no effect on judgment, but some of the gifts and favors which change hands do affect judgment, or they would not continue.

An unwelcome side effect of this rather unsubtle bribery is the frequent resentment which builds up with a purchasing organization when the other members of the department do not share in a supplier's largess to the extent they feel they should. This antagonism can greatly diminish the efficiency of a purchasing department.

It has been said that the pricing practices of many manufacturing concerns and suppliers have been a cause of the rise of payola in the field, for there is a dearth of competition among many material sources. Fair trade regulations and the coincidence of identical prices from all major sources on some hospital necessities, for the most part, have eliminated competition in its true sense. From a dollar-and-cents standpoint, it makes very little difference where hospitals buy many of their requirements. This is regrettable, but it is true. A possible result of this situation is for the salesmen or detail men handling these items to seek to influence selection on a basis of friendship, or payola. Occasional resistance is developing on the part of hospitals to the acceptance of gifts. Industry, too, is moving in many areas to take a firmer stand and to make regulations concerning both the offer and acceptance of "tokens of appreciation".

In our organization, we have a firm rule that such favors are not permitted, and our suppliers know of and respect our feelings. We print on the face of our purchase orders that "no member of our board of directors and no employee may accept any gift from any vendor with whom our district does business". As a direct result of this practice over the years, we buy competitive commodities at a lower price than a great many of our neighboring institutions and we still enjoy the respect and friendship of suppliers. Each knows that he will be treated fairly and exactly as his competitor is treated. ■

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References: (1) Roberts, H. J.: Am. J. Clin. Nutrition *8*:817-832 (Nov.-Dec.) 1960. (2) Tullis, I. E. and Allen, C. E.: Current Therap. Res. *3*:152-159 (April) 1961. (3) Tullis, I. E.; Allen, C. E., and Overman, R. R.: Simple Effective Weight Reduction: A Clinical Study, Scientific Exhibit, 6th Internat. Cong. Int. Med., Basel, Switzerland, Aug. 24-27, 1960. (4) Halpern, S. L.; Halpern, A. N., and Whitestone, I.: Treatment of Overweight in the Chronically Ill, Scientific Exhibit, 110th Ann. Meet., A.M.A., New York, June 25-30, 1961. (5) Antos, R. J.: Southwestern Med. *40*:695-697 (Nov.) 1959.

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DIETARY PROGRESS IN THE SMALLER HOSPITAL

by ANNA KATHERINE JERNIGAN

Food service personnel in Iowa hospitals are offered a variety of opportunities for increasing their knowledge and skills, according to the author. She states that similar means can be found in many other parts of the country for keeping abreast of a complex and a rapidly moving field.

THE WORLD of quantity food service is one where there is no room for assuming complacently that the knowledge gained yesterday will serve indefinitely in the future.

Regardless of their educational background, personnel in hospital dietary departments can add to their knowledge about quantity food service and can find interest in keeping up-to-date in this fast moving field. By lifting their sights occasionally from the relentless task of preparing three meals a day and by seeking knowledge about this important segment of hospital care, food service employees gain inspiration as well as information that will help them to improve hospital food service.

The problem of sharing knowledge about food service is particularly acute for food service personnel in smaller hospitals, where it is unlikely that the services of a professionally trained dietitian would be available. Approximately one third of the nation's hospitals are of less than a 50-bed size, and approximately 58 per cent are less than 100 beds in size. On a national basis, few recent figures exist on the training of food service personnel in hospitals of different sizes.

Work with hospitals in the Iowa State Department of Health has permitted making a summary of the training possessed by the persons responsible for food service in the 164 hospitals in Iowa, as shown in Table 1, p. 75. Probably the outstanding facts to be gleaned from this table are true in other areas of the country too—the use of the shared or part-time dietitian (in 25 Iowa hospitals or 15 per cent of the total number of hospitals) and the large number of hospitals where food service is managed by food service supervisors or cooks (in 80 Iowa hospitals or 49 per cent of the total number of hospitals).

An example of the type of on-the-job training that is available for food service personnel is the work done with Iowa hospitals by the Iowa State Department of Health. It also serves to show the type of opportunities that are available for food service personnel in other areas.

In Iowa, a basic tool for helping hospitals has been the *Simplified Diet Manual,* produced in cooperation with the Iowa Dietetic Association (second edition, July 1961, Iowa State University Press, Ames. $2.50). A copy of this manual has been presented to every hospital in Iowa and is used in the various teaching programs.

These teaching programs, directed particularly at the hospitals

Anna Katherine Jernigan is dietary consultant, Nutrition Service, Iowa State Department of Health, Des Moines, Iowa.

This article is adapted from a presentation at an American Hospital Association Institute for Shared Dietitians and Dietary Consultants held in May 1961.

TABLE 1—Training of persons responsible for food service in Iowa Hospitals

		No. of hospitals
Food service in state institutions (aided by director of food service [ADA*] for all state institutions)		6
Directed by dietitians (ADA)	2	
Hospital food service		
Directed by dietitians (ADA)		38
Managed by commercial food service company		5
With help of full-time dietitian (ADA)	1	
With help of part-time dietitian (ADA)	2	
Aided by part-time dietitian or supervisor		25
ADA dietitian	15	
Home economics graduate	10	
Managed by full-time home economics graduate		10
Managed by food supervisors or cooks		80
	Total	164

*Members of the American Dietetic Association

which lack the services of a full-time professionally trained dietitian, include the following:

1. Visits to the hospital by a consultant dietitian
2. District meetings for cooks and food service supervisors
3. Short course for food service supervisors at Iowa State University
4. Home study course
5. Workshop for shared dietitians.

Each of these programs has certain advantages, and probably a combination of them will serve better than any one alone. A discussion of each of these methods as used in Iowa will serve to show the possibilities latent in each.

CONSULTANT'S VISITS

1. *Visits to the hospital by a consultant dietitian.* In my experience, a visit with food service employees of a hospital can be educational for the consultant as well as the food service employees. There is no better way for a consultant to learn the areas where training is needed.

Such a visit is usually preceded by a letter to the hospital administrator requesting an appointment. Approximately four hours are spent at a hospital during a visit, planned so that the consultant can observe food being prepared, a meal being served and the cleanup procedure being carried out. Armed with her observations, the dietary consultant can then consult with the food service supervisor and the administrator with an analysis of the work done

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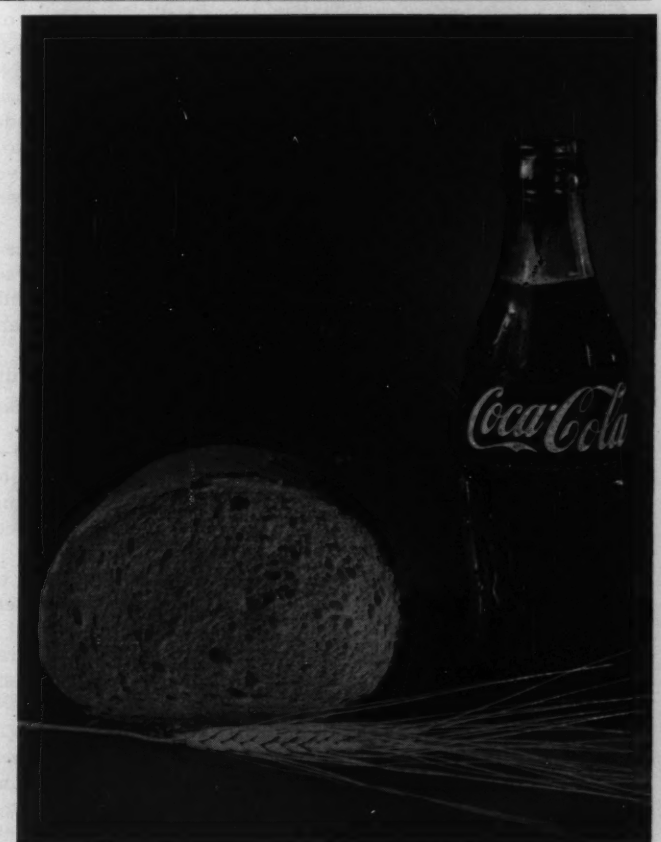

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and a few suggestions for improvement.

As a result of such visits, many job analyses have been written by the dietary consultant, menus for one week (prepared by cooks in approximately 40 hospitals) have been carefully evaluated and a few guides for cost systems have been worked out.

ONE-DAY MEETINGS

2. *District meetings* provide a good opportunity to bring information related to food service operation to the food service supervisor and to other employees in various areas of a state.

In Iowa, one-day district meetings are held in conjunction with the meetings for hospital administrators. The administrators usually attend some part of the program and also have lunch with the group. The ride to and from the meeting provides a good opportunity for the food service personnel and hospital administrators to get to know each other better and to discuss their own food service departments.

Iowa has been fortunate in having full cooperation of the dietitians in the state for district meetings. Usually members of the American Dietetic Association in the area are contacted to see who might be available to participate on the program; in every instance the members have been very willing to cooperate.

The best programs have been planned around one subject, with each speaker approaching the subject from a different angle. An example of this is one of the programs planned about diabetic diets. The following aspects of this subject were discussed:

a. The diabetic diet—a prescription—the importance of filling this prescription with accuracy

b. Planning luncheons for the diabetic

c. What the doctor expects from the dietary department when he orders a diabetic diet

d. Weights, measures and combinations of foods for a diabetic diet.

There have been 22 district meetings in Iowa during the past three years. Three hospital districts have asked for as many as five meetings; the other six districts each have had only one.

3. *The short course,* which is held for food service people from hospitals and state institutions and which is sponsored by the Iowa State University (Ames), is one of the highlights of Iowa's training programs. This short course lasts for one week and enrolls as many as 75 people. It has been found that the needs of the group have best been met by providing talks on general topics related to food service in the morning and by small group discussions and projects in the afternoon. One-fifth of the group spends the afternoon in the quantity food laboratory each day. This group has an opportunity to use food service equipment and to organize, prepare and serve the evening meal to all in attendance. The meal is always discussed the following morning by instructors, who analyze it from these approaches: nutritive value, suitability for modified diets, appearance, food service organization and cost.

CORRESPONDENCE COURSE

4. *The home study course* was developed because of the realization that even though training had been provided for many food service employees in Iowa, many others had not yet been reached. A number of teaching materials had been prepared by the Nutrition Service of the Iowa State Department of Health.

At first these materials were given to the food service employees when a visit was made to their hospital. However, the consultant soon realized that too much information given at one time is not used effectively. Because of this, each subject was developed into one lesson with an accompanying set of questions. The 14 topics developed were the following:

Menus—Check for Nutritional Adequacy

Menu Planning Technique

General Diet

Diet for the Older Person and Full Liquid Diet

Low Residue Diet and Bland Diets

Bland Diets (continued) and Soft Diets

Diabetic Exchange Lists

Sodium Restricted Diets

Practice in Menu Planning
Meat Preparation
Vegetable Preparation
Salad Preparation
Sanitation—Dish Machine Operation, Pot and Pan Washing, and Safety
Personal Cleanliness and Care of Hot Food.

These 14 lessons became the *home study course*. An explanatory letter, an outline and a student information sheet were sent to 36 smaller hospitals which had not participated in the other training programs. Approximately 20 of these hospitals responded. At present 84 students representing approximately 40 hospitals are participating in the home study course. Statements indicating completion of the course have already been awarded to 25 students. At present a six-month follow-up lesson is being contemplated.

One secret of the success of the home study course is the low cost involved—only 14 stamps and envelopes. Also, the student is not required to leave home or to miss work, and each student may progress at her own speed.

Each lesson is evaluated and returned with comments. Materials will be revised from time to time, and a few lessons may be added. Therefore, this course should continue to be useful.

UPDATING DIETITIANS

5. *Workshop for shared dietitians.* Actually the typical "shared" dietitian in Iowa is a part-time dietitian who divides her time between her family and the hospital in her community rather than being shared by various hospitals. Three years ago, only three home economists and one dietitian (ADA) were serving as part-time or shared dietitians. Today there are 25 such shared dietitians.

Because of the tremendous expansion of this type of service, the Nutrition Service of the Iowa State Department of Health sponsored a workshop for these women last April. The program included instruction on newer trends in diet therapy plus discussion about what each shared dietitian was doing for her hospital.

Typically a part-time dietitian works approximately one day a week to provide guidance to the food service department of the hospital in her community. She usually confers with patients and gives individual diet instructions. She may also write menus, furnish specifications for purchasing and do some on-the-job training of food service employees. These dietitians are also able to fulfill their duties as mothers and homemakers and also contribute to the welfare of their communities. The opportunity to serve stimulates them to keep abreast of new information in the field of dietetics.

* * *

The will to learn is the most important ingredient in the teaching process. By consultations, by classes, by private reading or study, by a variety of opportunities offered in different areas, food service personnel can increase their knowledge about this field. Part of the task of the dietary consultant is spreading the missionary spirit—of the importance of hospital food service for the well-being of the patient, as well as his comfort. ■

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Thanksgiving Day Menu Inserts

To reconcile patients to a holiday spent in the hospital, extra effort at food as well as friendliness is called for. The authors of selective cycle menus in this Journal have submitted menus for the four regions of the country to help hospitals plan their Thanksgiving Day menus.

The menu for Thanksgiving Day (November 23) is to be inserted in the fall menu cycle which was published in the July and August issues of the Journal. When these menus are substituted for the menus that would otherwise be used in this week, appropriate changes must be made in the order for perishables.

Turkey is a national bird, and appears on the menu for all four regions. Fortunately turkey is also a food that can be used on most modified diets, although the type of dressing and certain other accompaniments may require changes.

The menus provide for flexibility so that both "full" or "general" diets and "soft" and other modified diets may be selected.

Frances Hoffman, administrative dietitian, Women and Children's Hospital, Baylor University Medical Center, Dallas, Tex., author of the menu for the South-Southwest, forwarded a suggestion for making turkey tray favors. A medium-sized prune forms the body of the turkey, and a large gum drop is used for the base that supports this cheerful looking bird. Two colored toothpicks of

THANKSGIVING DAY SELECTIVE MENU FOR THE MIDWEST, SOUTH-SOUTHWEST, EAST AND NORTH-NORTHWEST

	morning	noon	night
Midwest	Spiced Dried Fruit Compote (F) **or** Apple Juice (S) Cream of Wheat **or** Corn Flakes Scrambled Eggs with Chives Tiny Sausage Cakes Cinnamon Crunch Coffee Cake	Lime Sherbet in Orange Juice (FS) Roast Tom Turkey (FS) with Chicken Liver Dressing Mashed Sweet Potato Puffs (F) **or** Snowflake Potatoes (S) Buttered Peas with Basil (FS) **or** Glazed Chestnuts Cranberry-Orange Mold **or** Celery, Olive, Radish Salad Hot Mince Pie with Rum Sauce (F) **or** Baked Pumpkin Souffle with Whipped Cream (S) Nuts — Mints	Beef Consomme with Rice (FS) Roast Sirloin of Beef (FS) **or** Ham Sandwich Plate Baked Idaho Potato (FS) Buttered Broccoli with Caper Sauce (F) **or** Buttered Carrots (S) Sliced Tomato Salad **or** Tossed Fruit Salad Banana Date Cake (F) **or** Stewed Peaches (S)
South-Southwest	Stewed Apricots (F) **or** Orange Juice (S) Oatmeal **or** Crisp Rice Cereal Scrambled Eggs Crisp Bacon Cinnamon Toast	Tomato Juice (S) Roast Turkey (FS) and Cornbread Dressing with Giblet Gravy (F) Cranberry Sauce (F) **or** Cranberry Jelly (S) Mashed Potatoes (FS) **or** Glazed Sweet Potatoes Buttered Peas with Mushrooms (FS) **or** Creamed Onions Jellied Waldorf Salad **or** Relish Plate (Celery, Pickle, Olive, Radish) Hot Rolls (F) Pumpkin Pie with Whipped Cream (F) **or** Fruit Cup with Sherbet	Cream of Asparagus Soup (FS) Cheese Souffle (FS) **or** Country Fried Steak with Gravy Baked Potato (FS) Broccoli with Lemon Butter (F) **or** Glazed Julienne Carrots (S) Canned Fruit Salad with Honey Dressing **or** Green Salad with Oil and Vinegar Dressing Butterscotch Brownies (F) **or** Vanilla Ice Cream (S)
East	Apricot Nectar (FS) **or** Fruit Gems Cooked Refined Wheat Cereal **or** Corn Flakes Cinnamon Coffee Ring **or** Buttered Toast Points	Egg Drop Soup (FS) **or** Chilled Cider Roast Turkey with Giblet Gravy (FS) — Chestnut Dressing (F) — Bread Dressing (S) Candied Sweet Potatoes (F) **or** Baked Potato (FS) Buttered Peas (S) with Slivered Blanched Almonds (F) **or** Tiny Whole Onions in Savory Cream Sauce Relish Plate: Carrot Curls, Celery Sticks, Spiced Crabapple Garnish Pumpkin Pie with Topping (F) **or** Holiday Ice Cream (S) Salted Nuts and Mints	Cream of Mushroom Soup **or** Turkey Vegetable Soup Cubed Steak with Catsup (FS) **or** Fruit Salad Medley with Raspberry Cottage Cheese Mold, Fruit Dressing Buttered Noodles (FS) Parisienne Wax Beans (F) **or** Carrot Coins (S) Tossed Salad Bowl with French Dressing Scones and Honey Peppermint Fluff with Molasses Cookies (FS)
North-Northwest	Fresh Grapefruit Half with Maraschino Cherry Garnish (F) **or** Fresh Frozen Orange Juice (S) Oatmeal **or** Corn Flakes Fried Egg **or** Bacon Danish Roll	Hot Spiced Cider with Wheat Crackers (F) Roast Tom Turkey (FS) with Oyster Dressing and Cranberry Sauce (F) Glazed Sweet Potatoes (F) **or** Mashed Potatoes with Giblet Gravy (S) Creamed Tiny Onions and Peas (F) **or** French Cut Green Beans (S) Molded Hawaiian Fruit Salad with Mayonnaise **or** Cottage Cheese Peach Salad Butter Puff Roll with Butter Mincemeat Pie (F) **or** Orange Sherbet with Cookies (S)	Potato Chowder Turkey Salad Sandwich with Potato Chips and Pickles (F) **or** Escalloped Potatoes and Dried Beef Casserole (S) Stewed Tomatoes (F) **or** Buttered Sliced Beets (S) Sour Cream Fruit Salad **or** Chinese Cabbage with Bleu Cheese Dressing Decorated Cupcake (FS) **or** Pumpkin Custard

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

Midwest Thanksgiving Day menu was prepared by Katherine Elman, director of food service, Louis A. Weiss Memorial Hospital, Chicago.

South-Southwest Thanksgiving Day menu was prepared by Frances Hoffman, administrative dietitian, Women and Children's Hospital, Baylor University Medical Center, Dallas, Tex.

East Thanksgiving Day menu was prepared by Ruth Sheinwald, director of dietetics, Beth Israel Hospital, Boston.

North-Northwest Thanksgiving Day menu was prepared by Irma Natvig, formerly head dietitian, Sioux Valley Hospital, Sioux Falls, S. Dak.

appropriate length form the turkey's legs. The turkey's head is formed by a coiled white pipe cleaner which is painted underneath with red nail polish. To make the tail, Miss Hoffman advises: "Insert two clipped turkey feathers in the other end of prune to form the turkey's tail feathers. Feathers about 1½ inches in length should be used and are most effective if one smooth feather is inserted just above a fluffier feather."

Those with an artistic bent in the food service department may want to try their hand at these tray favors.

In a letter accompanying her Thanksgiving Day menus for the East, Ruth Sheinwald, director of dietetics, Beth Israel Hospital, Boston, writes that in her "night" or supper menu Parisienne Green Beans are made by the addition of chopped green peppers and red pimentos to green beans.

Mrs. Irma Natvig, formerly head dietitian, Sioux Valley Hospital, Sioux Falls, S.Dak., author of the menu for the North-Northwest, forwards a recipe for Cranberry Punch, which is composed of half and half cranberry juice and a carbonated drink. Just before serving a small dipperful of lime sherbet is placed atop the punch.

Mrs. Natvig's recipe for Sour Cream Fruit Salad, included in the Thanksgiving evening menu, calls for one quart each of sour cream, drained mandarin oranges, drained pineapple chunks, drained peaches, and miniature marshmallows, plus one pint of shredded coconut. These ingredients are combined, and the salad is allowed to stand overnight in the refrigerator. A No. 10 dipper is used for portioning this salad, which is served on leaf lettuce and garnished with a maraschino cherry half. (This recipe yields 24 servings.) ■

NOTES AND COMMENT

Turkey talk—for holidays and year-round

The turkey situation has changed considerably since the days of the Pilgrim Fathers, when a recipe properly began with the advice: "Load your trusty musket."

The traditional holiday bird has even changed his shape. Turkeys have been bred to yield a larger proportion of white meat. Now eaten year-round as well as at Thanksgiving and Christmas, turkey is marketed in halves and parts as well as whole, and is subjected to a large variety of treatments, including boning, smoking, freezing, grinding and preparing in casseroles or entrees, before it reaches the hospital kitchen.

PURCHASING

In buying whole birds for institutional use, the 20 to 24-lb. size (dressed weight) is usually selected for roasting because it yields

(Continued on page 83)

The following organizations furnished information and photographs for this article: David W. Evans and Associates, Salt Lake City, Utah; National Turkey Federation, Mount Morris, Ill., and Poultry and Egg National Board, Chicago.

(ABOVE) Turkey meat may be used in many modified diets served to hospital patients, although the traditional accompaniments, such as gravy, stuffing and cranberry sauce, must sometimes be omitted. (BELOW) Serving turkey parts is a change from serving sliced roast turkey. Here, pan-fried drumstick from a small fryer-roaster (4 to 5 lb.) is served with tomatoes, green onions, lettuce, spinach, hard boiled egg, roll, butter and milk.

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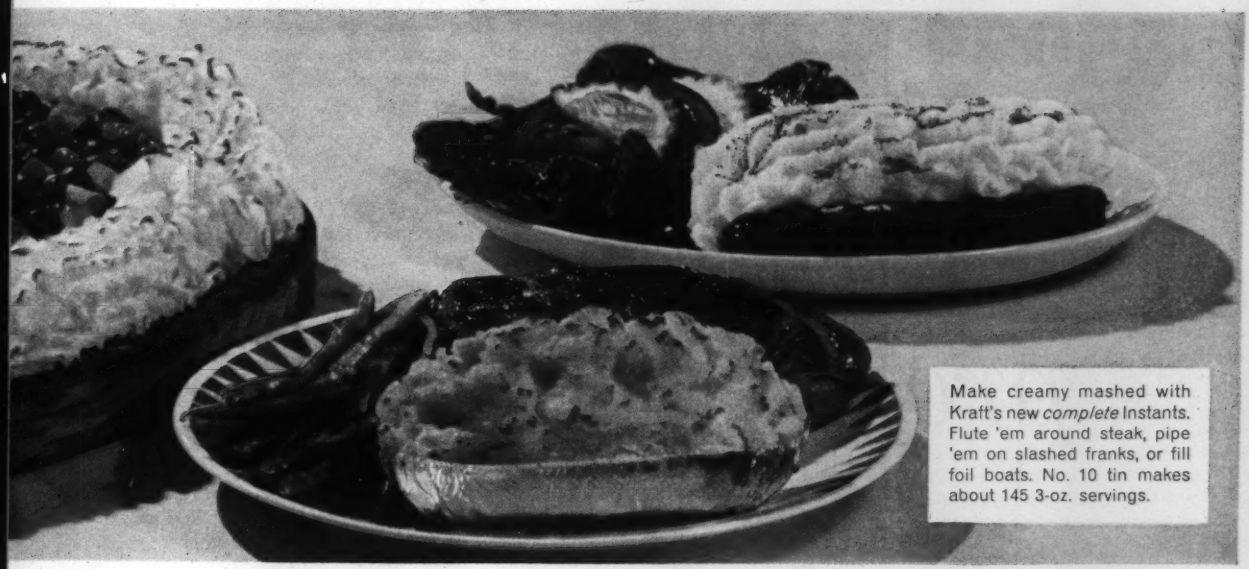

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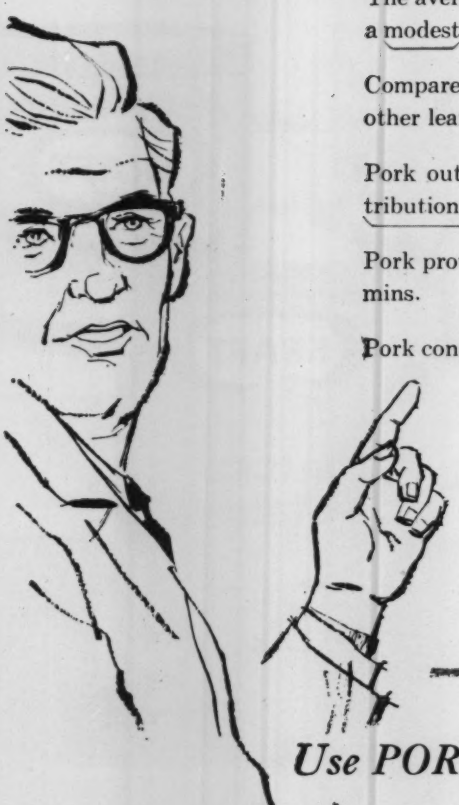

The average serving of 100 gm. of lean pork provides a modest 250 calories(1).

Compare the fat content of lean pork with that of other lean meats.

Pork outranks other high-protein foods in its contribution of thiamine(B1).

Pork provides an important amount of other B vitamins.

Pork contributes significant amounts of the essential minerals, iron, copper and phosphorus, magnesium and potassium, supplied in a form that the body can use readily.

1. Leverton, R.M., and Odell, G.V.: The Nutritive Value of Cooked Meat, Oklahoma Agricultural Experiment Station, Oklahoma State University, Miscellaneous Publication MP-49, 1958.

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The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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a higher proportion of meat to bone than smaller sized turkeys. At this weight, young tom turkeys are preferable to young hens because they usually contain less fat. For roasting whole, when the appearance of the cooked bird is important, Grade A turkeys are preferable, although when the turkey meat is to be used in salads and casseroles, less expensive grades may be used. Turkey parts are often used in hospitals, too, and are obtained from birds weighing 4 to 5 lbs. (fryer-roasters).

In buying turkey, allow approximately ½ to ¾ lb. turkey per serving or 50 to 75 lbs. (dressed weight) for 100 servings. In a study of mature broad-breasted bronze turkeys (26.54 lb. average live weight), Scott* found that oven ready birds weighed 77.7 per cent of the live weight and the edible part of the roasted turkey was 45.9 per cent of the live weight. This means that of the oven-ready weight of this type of turkey, approximately 60 per cent is edible meat. The rest are inedible parts, such as bone, or the liquid and fat which is lost in cooking by evaporation and dripping.

COOKING

For cooking whole turkeys, low-temperature roasting, uncovered, at an oven temperature of 325° F. is recommended. To keep it from drying out, the turkey may be rubbed with fat and covered with a loose cap of aluminum foil. Considerable time can be saved by roasting turkey unstuffed and by baking the dressing separately. A turkey weighing between 20 to 24 pounds requires approximately 6½ to 7 hours roasting time.

Turkey is "done" when the thickest part of the drumstick feels very soft or when the temperature registered by a meat thermometer placed in the center of the inside thigh muscle reaches 190° F.

A variety of other ways are often used for cooking turkeys in institutions, such as oven braising (cooking covered, with a small amount of liquid), simmering, and steaming with and without pressure. For flavor and juiciness, the low-temperature dry roasting of a high quality bird yields superior results, in the experts' judgment. Method of cookery is important; it can determine whether a turkey becomes an epicurean delight or something resembling old plastic.

FOOD SANITATION

All the rules of food sanitation should be observed in cooking and serving turkey and in the care and use of turkey leftovers. Improperly handled turkey meat, broth, or stuffing may be the vehicle for food poisoning.

The Poultry and Egg National Board suggests the following rules, among their *Turkey Tips for Group Service:*

"Cleanliness of working areas and cooking utensils is absolutely essential. Hands should be clean, free from cuts or infections. Workers with a cold, sore throat or fever should not handle food in preparation or serving.

"Serve all cooked foods promptly. After the food service is completed, refrigerate leftovers as soon as possible. Before refrigerating, kettles or pans of hot food may be cooled rapidly by placing them in sink with running cold water circulating around them."

TURKEY IN MODIFIED DIETS

Turkey meat fits into soft and most other modified diets unless contraindicated in individual cases. Served plain sliced, one ounce of lean turkey may be considered as one "meat exchange" or equivalent to one ounce lean beef, one egg, etc. Three ounces of cooked sliced turkey (no bone) is a portion size often used in hospitals. Turkey cooked and served without salt may be used in most sodium-restricted diets. (Smoked turkey may not be used in such sodium-restricted diets.) While lean cooked turkey itself fits into most modified diets, any accompaniments such as gravy or stuffing, or any other ingredient in a mixed dish must be evaluated separately when planning diets. ■

*Scott, M. L. Composition of turkey meat. *J.Am.Diet.Assn.* 32:941 Oct. 1956.

Recipes from Beth Israel Hospital, Boston

Some favorite menu items at Beth Israel Hospital in Boston are included in the selective cycle menus for the East beginning on

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page 85. Ruth Sheinwald, director of dietetics, who prepared these cycle menus, reports that her hospital's dietary department is in the process of converting to a central service and that these cycle menus will be used in the new service. For better quality and cost control, a special printed form of recipe card, measuring 5 by 8 inches, is used, with space provided on one side for periodic calculation of cost per serving.

Two of the recipes used at this hospital follow.

LUKSHEN KUGLE
(210 servings)

10 lbs. noodles
15 lbs. cottage cheese
16 qts. milk
80 eggs
¾ c. salt
3 lbs. 8 oz. brown sugar
3 lbs. 8 oz. raisins
½ c. cinnamon

1. Boil noodles in salted water; drain well.
2. Mix together all other ingredients except raisins.
3. Place in 7 pans (each pan measuring 11½ x 19 x 2½ inches), alternating cooked drained noodles and milk-cheese mixture. Sprinkle raisins over all.
4. Bake 45 minutes in 350° F. oven. Divide each pan into 30 portions, each portion measuring approximately 2 x 3½ inches.

MOCK CHEESE BLINTZES
(100 servings)

50 eggs
3 qts. milk
6 loaves sandwich bread, pullman #3 (32 slices per loaf)
10 lbs. cottage cheese
10 egg yolks
8 oz. sugar
8 oz. melted butter
2 tbsp. cinnamon
3 tbsp. salt

1. Mix together eggs and milk. Reserve.
2. Trim crusts from bread.
3. Mix together cottage cheese, egg yolks, sugar, melted butter, cinnamon and salt.
4. Place 1 heaping tablespoon of cottage cheese mixture on 1 slice trimmed bread; roll; place cut side down in greased pan (30 blintzes in each pan measuring 11½ x 19 x 2½ inches).
5. Drizzle reserved egg and milk over blintzes.
6. Bake in 350° F. oven for 45 minutes. Serve 2 blintzes per portion.

Winter Cycle Menu for the East

THE 21-DAY selective winter cycle menu and market orders for perishables are designed for hospitals in the East. These menus, which are to be used during December, January and February, feature foods popular in the eastern section of the United States.

The menus in this issue are the third in a four-part series of fall cycle menus published in this Journal. Winter cycle menus for the Midwest and South-Southwest were included in the October 1 and 16 issues of **HOSPITALS**, J.A.H.A. Winter menus for the North-Northwest section of the country will be published in the November 16 issue.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. A moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item is for the full and soft diets.

The fall cycle menus, which may be used during November, were published in the July and August issues of this Journal.

In adapting items marked (S) for use on modified diets, it should be noted that certain items will need sodium or fat restriction during preparation, if they are to be served on sodium restrictive or fat restrictive diets. When fruits are included on the dessert menu, the dietitian will omit sugar in preparation or substitute the water-packed variety for the diabetics.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 80 patient and personnel meals at breakfast, 120 at noon and 80 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry, etc.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

1st WEEK EAST WINTER SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING DECEMBER, JANUARY AND FEBRUARY)

—prepared by Ruth Sheinwald, director of dietetics
Beth Israel Hospital, Boston

	morning	noon	night
monday	Sectioned Orange Halves (F) **or** Grape Juice (S) Cooked Whole Wheat Cereal **or** Puffed Rice Cereal Scrambled Eggs Raisin Toast	Cream of Celery Soup Roast Leg of Lamb and Gravy (FS) **or** Egg Salad Plate: Tomato Wedges, Carrot Sticks, Black Olives Baked Potato (FS) **or** Mashed Potatoes Asparagus Spears (FS) Farmer's Salad **or** Peach Melba Salad Hot Roll Cherry Crisp (FS) **or** Canned Fruit Cocktail	Chicken Gumbo Soup Sauteed Liver (S) and Onions (FS) **or** Italian Spaghetti with Meat Sauce, Parmesan Cheese Mashed Potatoes (FS) Peas (FS) **or** Whipped Squash Spring Salad Bowl **or** Apricot Medley Hard Roll Gingerbread with Whipped Cream (F) **or** Danish Dessert (S)
tuesday	Orange Juice (FS) **or** Banana Cooked Refined Wheat Cereal **or** Corn Flakes Poached Eggs Jelly Muffin	Cream of Mushroom Soup Hot Sliced Chicken Sandwich (S) and Gravy with Cranberry Sauce (F) **or** Large Fruit Salad Plate: Citrus Sections, Apple Slices, Canned Plums, Banana Wedges and Cottage Cheese, Melba Toast Baked Potato (FS) **or** Mashed Potatoes Spinach (FS) Tossed Greens **or** Black-Eyed Susan Salad Hermits (F) Canned Peach Halves (S)	Beef Alphabet Soup Yankee Pot Roast with Gravy (FS) **or** Veal Ragout Delmonico Potatoes (FS) Tiny Whole Beets (FS) **or** Broccoli Combination Salad **or** Lemon Gingerale Mold French Apple Pie (F) Applesauce (S)
wednesday	Half Grapefruit (F) **or** Apricot Nectar (S) Oatmeal **or** Ready-to-Eat Wheat Flakes Soft Cooked Eggs Fruit Muffin	Cream of Tomato Soup Cubed Steak with Catsup (FS) **or** Cheese Souffle Baked Potatoes (FS) **or** Country Fried Potatoes Pimento Wax Beans (F) Bermuda Salad Bowl **or** Petite Canned Fruit Salad Whole Peeled Apricots (FS) **or** Mocha Pudding with Light Cream	Scotch Broth Broiled Swordfish with Lemon Wedge (FS) **or** Baked Meat Loaf with Gravy Mashed Potatoes (FS) Whipped Squash (FS) **or** Buttered Mixed Vegetables Tossed Raw Vegetable Salad **or** Blushing Pear Salad Cupcake with Pistachio Icing (FS) **or** Fresh Grapes
thursday	Orange Juice (FS) **or** Baked Apple Cooked Malted Wheat Cereal **or** Puffed Wheat Cereal Fried Eggs Bran Muffin	Cream of Potato Soup Roast Veal and Gravy with Currant Jelly (FS) **or** Mushroom Omelet Mashed Potatoes (FS) **or** Baked Potato Asparagus Spears (FS) Caesar Salad **or** Tropical Fruit Mold Fig Square (F) **or** Vanilla Ice Cream (S)	Beef Noodle Soup Corned Beef with Mustard Sauce (F) **or** Boiled Fresh Brisket (S) Parsley Boiled Potato (FS) Carrot Coins (FS) **or** Steamed Cabbage Chef's Salad Bowl **or** Old Fashioned Fruit Salad Hot Roll Strawberry Chiffon Pie (F) **or** Strawberry Chiffon Pudding (S)
friday	Blended Juice (FS) **or** Kadota Figs Cooked Whole Wheat Cereal **or** Ready-to-Eat Rice Cereal Scrambled Eggs Cherry Muffin	Fish Chowder and Oysterettes Baked Macaroni and Cheese (FS) **or** Hot Sliced Beef on Bun with Barbecue Sauce Spinach (FS) **or** Buttered Green Beans Spring Salad **or** Hawaiian Lei Salad Gelatin Cubes with Sherry Sauce (FS) **or** Frozen Sliced Peaches	Navy Bean Soup Baked Stuffed Fillet of Sole with Parsley Sprig (FS) **or** Broiled Lamb Chop with Mint Jelly Mashed Potatoes (FS) Peas (FS) **or** Stewed Tomatoes Perfection Salad Mold **or** Banana Nut Log Salad Orange Coconut Cake with Orange Icing (F) **or** Fresh Applesauce (S)
saturday	Stewed Prunes (F) **or** Orange Juice (S) Cooked Refined Wheat Cereal **or** Shredded Wheat Cereal Poached Egg Butterscotch Bun	Cream of Asparagus Soup Salisbury Steak and Brown Gravy (FS) **or** Chinese Egg Roll with Sauce Au Gratin Potatoes (FS) **or** Baked Potato French Style Green Beans (FS) Tossed Greens **or** Under the Sea Salad Mold Chocolate Pudding with Light Cream (FS) **or** Butterscotch Brownie	Chicken Noodle Soup Roast Chicken with Dressing and Giblet Gravy (FS) **or** Cold Cut Salad Plate: Lettuce Cup, Cucumber Slices Radish Rose, Black Olives Mashed Potatoes (FS) Whipped Squash (FS) **or** Tiny Whole Onions Lettuce Wedge **or** Peach Melba Salad Pan Roll Blueberry Cobbler (F) **or** Angel Cake (S)
sunday	Grapefruit Juice (FS) **or** Pineapple Tidbits Oatmeal **or** Ready-to-Eat Sweetened Wheat Cereal French Toast and Syrup Cinnamon Doughnuts (F)	French Onion Soup with Croutons Roast Prime Ribs of Beef Au Jus (FS) **or** Chicken Chow Mein on Fried Noodles Mashed Potatoes (FS) Sliced Beets (FS) **or** Brussels Sprouts Stuffed Celery, Ripe Olives Chocolate Mint Sundae (F) **or** Vanilla Ice Cream (S)	Cream of Pea Soup Cubed Beef with Mashed Potato Topping en Casserole (FS) **or** Baked Haddock in Milk and Buttered Crumbs with Lemon Garnish Buttered Rice (FS) Asparagus Spears (FS) Tossed Greens **or** Fruit Salad Bowl Oatmeal Raisin Cookies (F) **or** Sugar Cookies (S) with Sliced Peaches

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Corned (Boneless)	U. S. Good	20 lbs.	60
Brisket, Fresh (Boneless)	U. S. Good	7 lbs.	20
Chuck-eye Roll (Boneless)	U. S. Good	34 lbs.	100
Ground Beef	U. S. Good, 5 lb. pkg.	30 lbs.	
Liver	Steer, sliced	15 lbs.	60
Round (Bottom)	U. S. Standard	27 lbs.	80
Steaks, Cubed	U. S. Choice, 4 oz. each	20 lbs.	80
Stew	U. S. Good	15 lbs.	60
LAMB			
Chops, Loin	U. S. Choice, 6 oz. each	7 lbs. 8 oz.	20
Leg (B.R.T.)	U. S. Choice, yearling	27 lbs.	80
PREPARED MEATS			
Assorted Cold Cuts		4 lbs.	20
VEAL			
Leg (B.R.T.)	U. S. Good	27 lbs.	80
Stew	U. S. Good	5 lbs.	20
FISH			
Haddock	Fillets, skinless	5 lbs.	20
Sole	Frozen, fillets	15 lbs.	60
Swordfish	Steaks, 5 oz. each	18 lbs. 12 oz.	60
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	90 lbs.	120
Fryers (Eviscerated)	Grade A, 2½ lb. av.	45 lbs.	60
FRESH FRUITS			
Apples, Baking	Baking, 113s	7 lbs.	
Bananas	Ripe	50 lbs.	
Grapefruit	Seedless, 70s	½ box	
Grapes	Tokay	5 lbs.	
Lemons		1 doz.	
Oranges	176s	7 doz.	
FRESH VEGETABLES			
Cabbage	Bag	5 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 doz.	
Cucumbers		18 cukes	
Escarole		12 heads	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Parsley	Bunch	1 doz.	
Peppers, Green		5 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Romaine	Ham., 24's	1 ham.	
Tomatoes	Repacked (5 x 6)	18 lbs.	
FROZEN FRUITS			
Blueberries	Dry, 8 lb. can	2 cans	
Grapefruit Juice	Con., 32 oz. can	3 cans	
Orange Juice	Con., 32 oz. can	3 cans	
Orange and Grapefruit Sections	Fresh, chilled, gallon	3 gal.	
Peaches	Sliced, 8 lb. can, 5-1 sugar	2 cans	
Strawberries	Sliced, 8 lb. can, 5-1 sugar	1 can	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	40 lbs.	240
Beans, Green	Cuts, 2½ lb. pkg.	2½ lbs.	15
Beans, Green	Julienne, 2½ lb. pkg.	15 lbs.	90
Beans, Wax	Cuts, 2½ lb. pkg.	15 lbs.	90
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	20 lbs.	120
Spinach	Chopped, 2½ lb. pkg.	30 lbs.	180
Squash, Winter	3 lb. pkg.	36 lbs.	135
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

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2nd WEEK EAST WINTER SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING DECEMBER, JANUARY AND FEBRUARY)

—prepared by Ruth Sheinwald, director of dietetics
Beth Israel Hospital, Boston

	morning	noon	night
monday	Citrus Sections (F) or Apple Juice (S) Malted Wheat Cereal or Ready-to-Eat Wheat Cereal Poached Egg Toasted English Muffin	Cream of Vegetable Soup Roast Stuffed Breast of Veal with Currant Sauce (FS) or Potato Pancakes and Hot Cinnamon Applesauce Mashed Potatoes (FS) or Baked Potato Wax Beans (FS) Tossed Greens or Bing Cherry Mold Old Fashioned Bread Pudding (FS) or Chilled Canned Apricots	Beef Barley Soup Chicken Fricassee (FS) or Hot Sliced Brisket of Beef with Horseradish Sauce Buttered Rice (FS) Julienne Carrots (FS) or Buttered Lima Beans Raw Vegetable Salad Bowl or Waldorf Salad Banana Cake with Lemon Icing (FS) or Fruit Cup
tuesday	Grapefruit Juice (FS) or Purple Plums Cooked Whole Wheat Cereal or Corn Flakes Scrambled Egg Buttermilk Muffin	Cream of Tomato Soup Broiled Hamburger on Bun (S) with Mustard, Ketchup and Relish (F) or Baked Fluffy Omelet Mashed Potatoes Buttered Steamed Cabbage (F) or Buttered Spinach (S) Relish Plate or Pineapple Medley Salad Chewy Fruit Bar (F) or Gelatin Cubes (S)	Creole Soup Broiled Sirloin Steak (S) with Mushroom Cap (F) or Cold Plate with Sliced Beef, Potato Salad, Tomato Wedges, Sweet Mixed Pickles Escalloped Potatoes (FS) Creole Eggplant (F) or Peas (S) Caesar Salad or Molded Fruit Salad Bridge Roll Pecan Pie (F) or Canned Pear Halves and Molasses Cookie (S)
wednesday	Quartered Navel Orange (F) or Tomato Juice (S) Cooked Refined Wheat Cereal or Puffed Rice Cereal Soft Cooked Egg Blueberry Muffin	Cream of Celery Soup Roast Duck and Prune Dressing with Orange Sauce (F) or Broiled Halibut with Lemon Butter Sauce (S) Mashed Potatoes (FS) or Hash Browned Potatoes Asparagus Spears (FS) Tossed Greens or Banana Royal Salad Apple Crisp with Topping (FS) or Chilled Plums in Syrup	Chicken Rice Soup Broiled Veal Chop with Grape Jelly (FS) or Baked Cheese Dreams with Syrup Mashed Potatoes (FS) Tiny Whole Beets (FS) or Corn Niblets Jewel Salad Mold or Apricot with Cottage Cheese Salad Chocolate Eclair (F) or Vanilla Pudding (S)
thursday	Orange Juice (FS) or Baked Apple with Raisins Oatmeal or Ready-to-Eat Wheat Cereal Fried Egg Date Muffin	Cream of Mushroom Soup Roast Lamb and Gravy with Mint Jelly (FS) or Baked Lasagne Baked Potato (FS) Buttered Green Beans (FS) or Buttered Cauliflower Carrot, Raisin Salad or Frozen Fruit Salad Silver Cake with Peppermint Icing (FS) or Royal Anne Cherries	Minestrone Soup Beef a la Mode (FS) or Large Fruit Salad Plate: Pineapple Ring Filled with Raspberry Cottage Cheese Cubes, Banana Quarters, Peach Slices, Queen Anne Cherries Baked Potato (FS) Whipped Squash (FS) or Broccoli Hollandaise Chef's Salad or Citrus Ambrosia Salad Scones with Jelly Lemon Meringue Pie (F) or Lemon Meringue Pudding (S)
friday	Stewed Fruit Compote (F) or Blended Juice (S) Malted Wheat Cereal or Shredded Wheat Cereal Poached Egg Orange Nut Muffin	Corn Chowder Beef Sauerbraten (FS) or Tuna Salad Plate with Potato Chips, Queen Olives, Carrot Curls, Hard Cooked Egg Quarters Mashed Potatoes (FS) or O'Brien Potatoes Spinach (FS) Tossed Greens or Twin Orange Salad Sandwich Hot Roll Cranberry Crunch (F) or Canned Fruit Cocktail (S)	Pepperpot Soup Creamed Finnan Haddie on Toast Points (FS) or Veal Cutlet with Tomato Sauce Baked Potato (FS) Parslied Carrot Coins (FS) or Brussels Sprouts Vegetable Salad Mold or Fruit Salad Lady Baltimore Cake (F) or Fruited Gelatin
saturday	Grapefruit Half (F) or Prune Juice (S) Cooked Whole Wheat Cereal or Ready-to-Eat Rice Cereal Soft Cooked Egg Honey Crunch Coffee Cake	Cream of Carrot Soup Country Style Steak (FS) or Mock Cheese Blintzes with Sour Cream Mashed Potatoes (FS) or Baked Potato Asparagus Spears (FS) Grapefruit and Avocado Salad or Chef's Salad Date Bar (F) or Sponge Cake (S)	Chicken Vegetable Soup Broiled Chicken Breast (S) with Supreme Sauce (F) or Chopped Liver Salad Plate with Rye Bread, Sliced Tomato on Lettuce, Bread and Butter Pickles, Mayonnaise Oven Browned Potato (F) Peas (FS) or Cauliflower Polonaise Combination Salad or Cranberry Relish Mold Peach Shortcake with Whipped Cream (F) or Frozen Peaches with Whipped Cream (S)
sunday	Orange Juice (FS) or Kadota Figs Cooked Refined Wheat Cereal or Ready-to-Eat Whole Wheat Cereal Pancakes with Syrup Fruit Ring with Sugar Glaze	Beef Consomme Roast Prime Ribs of Beef Au Jus (FS) or Baked Whitefish Baked Potato (FS) Mixed Garden Vegetables (F) or Whipped Squash (S) Tossed Green Salad Bowl or Sliced Orange Salad Pineapple Sundae (F) or Coffee Ice Cream (S)	Cold Beet Borscht (FS) Broiled Beef Patty (S) with Mushroom Gravy (F) or Salmon Loaf with Pimento Sauce Duchess Potatoes (FS) French Style Green Beans (FS) Coleslaw or Old Fashioned Fruit Bowl Almond Macaroons (FS) or Fruit Cocktail

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Fresh	U. S. Choice	7 lbs.	20
Chuck-eye Roll (Boneless)	U. S. Good	47 lbs.	140
Ground Beef	U. S. Good, 5 lb. pkg.	40 lbs.	
Rib Roast	U. S. Choice	50 lbs.	95
Steaks, Cubed	U. S. Choice, 4 oz. each	20 lbs.	80
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	18 lbs. 12 oz.	60
LAMB			
Leg (B.R.T.)	U. S. Choice, yearling	27 lbs.	80
VEAL			
Breast		53 lbs.	80
Chops, Shoulder	U. S. Good, 5 oz. each	18 lbs. 12 oz.	60
Cutlets	U. S. Good, 4 oz. each	5 lbs.	20
FISH			
Finnan Haddie		15 lbs.	60
Halibut	Steaks, 5 oz. each	6 lbs. 4 oz.	20
Whitefish (Sea)	Fillets	20 lbs.	40

Item, Specifications, Amounts & No. of Servings			
POULTRY			
Breasts, Chicken		30 lbs.	60
Duck		100 lbs.	100
Fowl (Eviscerated)	Grade A, 5 lb. av.	45 lbs.	60
Livers, Chicken	1 lb. pkg.	5 lbs.	20
FRESH FRUITS			
Apples	Jonathan, 113s	14 lbs.	
Avocado	Ripe	5	
Bananas	Ripe	35 lbs.	
Lemons		1 doz.	
Oranges	176s	9 doz.	
FRESH VEGETABLES			
Cabbage	Bag	20 lbs.	
Carrots	Topped, bag	75 lbs.	
Celery	Pascal, 30s	1 doz.	
Cucumbers		14 cukes	
Eggplant		8 lbs.	
Escarole		16 heads	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Parsley	Bunch	1 doz.	
Pepper, Green		12 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	

Item, Specifications, Amounts & No. of Servings			
Radishes	Bunch	1 doz.	
Tomatoes	Repacked (5 x 6)	34 lbs.	
FROZEN FRUITS			
Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
Orange and Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
Peaches	Sliced, 8 lb. can., 5-1 sugar	2 cans	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	30 lbs.	180
Beans, Green	Cuts, 2½ lb. pkg.	15 lbs.	90
Beans, Green	Julienne, 2½ lb. pkg.	10 lbs.	60
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs.	15
Beans, Wax	Cuts, 2½ lb. pkg.	15 lbs.	90
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	5 lbs.	30
Peas	2½ lb. pkg.	12½ lbs.	75
Spinach	Chopped, 2½ lb. pkg.	17½ lbs.	105
Squash, Winter	3 lb. pkg.	18 lbs.	75
Vegetables, Mixed	2½ lb. pkg.	15 lbs.	90

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3rd WEEK EAST WINTER SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING DECEMBER, JANUARY AND FEBRUARY)

—prepared by Ruth Sheinwald, director of dietetics
Beth Israel Hospital, Boston

	morning	noon	night
monday	Stewed Apricots and Raisins (F) **or** Grapefruit Juice (S) Oatmeal **or** Puffed Wheat Cereal Scrambled Eggs Cinnamon Toast	Cream of Asparagus Soup Baked Macaroni and Cheese (FS) **or** Chicken Salad Plate with Potato Chips, Pickle Sticks, Tomato Wheels Baked Potato Spinach (FS) **or** Brussels Sprouts Tossed Raw Vegetable Salad **or** Banana Split Salad Parker House Roll Tapioca Pudding with Grape Jelly and Mint Leaf Garnish (FS) **or** Chilled Peach Half in Syrup	Beef Alphabet Soup New England Boiled Dinner: Corned Brisket (F) **or** Hot Sliced Beef (S), Boiled Potatoes (FS), Seven-Minute Cabbage (F), Tiny Whole Beets (FS) Tossed Greens **or** Fruit Salad in Gelatin on Romaine Devil's Food Cake with Fudge Frosting (FS) **or** Raspberry Sherbet
tuesday	Orange Juice (FS) **or** Pineapple Tidbits Malted Wheat Cereal **or** Ready-to-Eat Oat Cereal Soft Cooked Eggs Dutch Apple Cake	Cream of Potato Soup Barbecued Beef on a Bun (FS) **or** Vegetable Chow Mein on Fried Noodles Buttered Rice (FS) Asparagus Spears (FS) **or** Buttered Wax Beans Spring Salad **or** Pear with Cottage Cheese Salad Cottage Pudding with Raspberry Sauce (F) **or** Canned Pears (S)	Scotch Broth Roast Veal with Gravy (FS) **or** Sweet and Sour Meat Balls Parsley Potatoes (FS) Carrot Coins (FS) **or** Broccoli Caesar Salad **or** Pickled Beet Salad Cherry Pie (F) **or** Queen Anne Cherries (S)
wednesday	Banana (F) **or** Tomato Juice (S) Cooked Whole Wheat Cereal **or** Sugar Frosted Flaked Cereal Poached Eggs Corn Muffin	Cream of Tomato Soup Hot Pastrami on Roll with Mustard (F) **or** Creamed Seafood on Rusk (S) Baked Potato **or** Mashed Potatoes Green Beans (F) Coleslaw **or** Peach Melba Salad Pineapple Graham Cracker Pudding (F) **or** Canned Pear Half (S)	Cabbage Soup Omelet with Spanish Sauce (FS) **or** Pot Roast with Vegetable Gravy Mashed Potatoes (FS) Peas (FS) **or** Creamed Onions Lettuce Wedge **or** Apricot and Pineapple Salad Jelly Roll (FS) **or** Fruit Cup
thursday	Grapefruit Segments with Cherry Garnish (F) **or** Apple Juice (S) Cooked Refined Wheat Cereal **or** Corn Flakes Scrambled Eggs Peach Muffin	Cream of Mushroom Soup Roast Lamb with Mint Sauce (FS) **or** Fruit Salad Plate: Pear Halves, Orange Slices, Apple Wedges, Minted Pineapple, Banana Cubes, Date-Nut Cream Cheese Finger Sandwiches Au Gratin Potatoes **or** Baked Potato Spinach (FS) Lettuce and Tomato Salad **or** Rainbow Salad Mold Fudge Brownie (F) **or** Canned Peeled Apricots (S)	Beef Noodle Soup Broiled Liver (FS) **or** Beef Stew Oven Browned Potato (F) Buttered Carrots (FS) **or** Buttered Wax Beans Tossed Greens **or** Asparagus Salad Toasted Coconut Cream Pie (F) **or** Baked Custard (S)
friday	Orange Halves (F) **or** Grape Juice (S) Oatmeal **or** Ready-to-Eat Rice Cereal Fried Eggs Cranberry Muffin	Fish Chowder with Oysterettes Cheese Fondue (FS) **or** Baked Meat Loaf with Tomato Gravy Lyonnaise Potatoes (FS) Buttered Lima Beans (F) **or** Asparagus Spears (S) Perfection Salad **or** Peach Melba Salad Apricot Square (F) **or** Royal Anne Cherries (S)	Lentil Soup Baked Halibut with Egg Sauce (FS) **or** Pepper Steak Mashed Potatoes (FS) Corn Niblets (F) **or** Tiny Whole Beets (S) Chef Salad Greens **or** Hawaiian Lei Salad Angel Cake (S) with Strawberries (F)
saturday	Blended Juice (FS) **or** Baked Apple Malted Wheat Cereal **or** Ready-to-Eat Wheat Cereal Soft Cooked Eggs Pecan Roll	Cream of Pea Soup Lukshen Kugle (FS) **or** Baked Veal Chop with Jelly Baked Potato (FS) **or** Mashed Potatoes (FS) Wax Beans (F) Farmer's Salad **or** Limed Fruit Mold Dream Bar (F) **or** Whole Peeled Apricots (S)	Chicken Rice Soup Roast Turkey and Gravy (S) with Sage Dressing (F) **or** Steamed Frankfurts and Hot Potato Salad with Mustard and Relish Glazed Sweet Potatoes (FS) Peas and Mushrooms (FS) **or** Cauliflower with Cheese Sauce Perfection Mold **or** Fresh Fruit Bowl Ice Cream Sandwich with Butterscotch Sauce (FS) **or** Canned Peaches
sunday	Stewed Prunes (F) **or** Orange Juice (S) Cooked Whole Wheat Cereal **or** Puffed Rice Cereal Scrambled Eggs Bagel and Cream Cheese with Grape Jelly (FS) **or** Doughnut	Egg Drop Soup Roast Prime Ribs of Beef Au Jus (FS) **or** Swordfish Steak Potato Puffs (F) Carrot Coins (FS) **or** Garden Vegetables Relish Plate: Celery Fan, Carrot Curls, Spanish Olives (F) Marshmallow Sundae (FS) **or** Fruit Cup with Sherbet	Cream of Vegetable Soup Tuna a la King in Toast Baskets (F) **or** Creamed Tuna in Toast Baskets (S) Mashed Potatoes (FS) Spinach (FS) **or** Asparagus Spears Tossed Greens **or** Petite Canned Fruit Salad Toll House Cookies (F) **or** Refrigerator Cookies (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

PLEASE CUT ALONG THIS LINE

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Corned	U. S. Good	20 lbs.	60
Chuck-eye Roll (Boneless)	U. S. Good	40 lbs.	120
Frankfurters	All beef, 8-1 lb.	5 lbs.	20
Ground Beef	U. S. Good, 5 lb. pkg.	15 lbs.	
Liver	Steer, sliced	15 lbs.	60
Rib Roast	U. S. Choice	40 lbs.	80
Steaks, Cubed	U. S. Choice, 4 oz. each	5 lbs.	20
Stew	U. S. Good	5 lbs.	20
LAMB			
Leg (B.R.T.)	U. S. Choice, yearling	27 lbs.	80
PREPARED MEATS			
Pastrami		20 lbs.	
VEAL			
Chops, Shoulder	U. S. Good, 5 oz. each	12 lbs. 8 oz.	40
Leg (B.R.T.)	U. S. Good	20 lbs.	60
FISH			
Halibut	Steaks, 5 oz. each	18 lbs. 12 oz.	60
Swordfish	Steaks, 5 oz. each	12 lbs. 8 oz.	40
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	30 lbs.	40
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	45 lbs.	60
FRESH FRUITS			
Apples	Baking, 113s	7 lbs.	
Apples	Jonathan, 113s	14 lbs.	
Bananas	Ripe	33 lbs.	
Lemons		1 doz.	
Oranges	176s	6 doz.	
FRESH VEGETABLES			
Cabbage	Bag	40 lbs.	
Carrots	Topped, bag	120 lbs.	
Celery	Pascal, 30s	1 doz.	
Cucumbers		17 cukes	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Parsley	Bunch	1 doz.	
Peppers, Green		9 lbs.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Romaine	Ham., 24's	1	
Tomatoes	Repacked (5 x 6)	30 lbs.	
FROZEN FRUITS			
Grapefruit Juice	Con., 32 oz. can	1 can	
Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
Orange Juice	Con., 32 oz. can	3 cans	
Strawberries	Sliced, 8 lb. can, 5-1 sugar	2 cans	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	30 lbs.	170
Beans, Green	Cuts, 2½ lb pkg.	15 lbs.	90
Beans, Lima	Small. green, 2½ lb. pkg.	15 lbs.	90
Beans, Wax	Cuts, 2½ lb. pkg.	20 lbs.	120
Broccoli	Stems and buds, 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	20 lbs.	120
Spinach	Chopped, 2½ lb. pkg.	40 lbs.	240
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

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equipment and supply review

Fire door (21F-1)

Manufacturer's description: One of the characteristics of this door is that it will automatically close at a temperature of 160°F. A metal link that melts as soon as super-heated air from a fire reaches it releases a tension spring and shuts the door automatically. This device aids in closing the fire off from open corridors and stair wells. *Fenestra Inc., Dept. H21, 11801 Mack Ave., Detroit 14.*

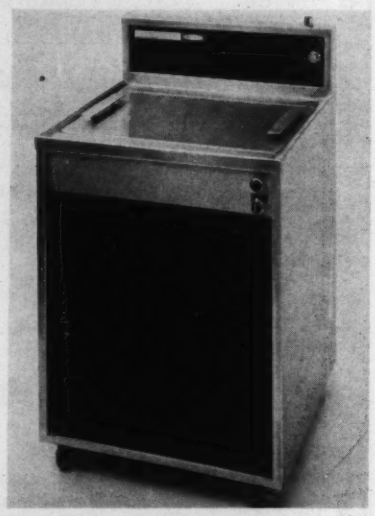
Intensive care beds (21F-2)

Manufacturer's description: Light in weight and easily movable, these adult and pediatric intensive care beds are fully equipped with heavy duty conductive casters, swivel locks and brakes. All mechanism is completely enclosed in a center channel with a removable top, and convenient cranks enable the beds to be placed in all required spring positions. Dual mattress guards prevent shifting of mattress, anodized aluminum side guards can be raised or lowered and the head and footends are completely removable. The bed from the floor to the top of the spring is 32 in. and provides a moulded bumper around the entire frame for added protection from walls and doorways. *Hill-Rom Co., Inc., Dept. H21, Batesville, Ind.*

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

Flask washer (21F-3)

Manufacturer's description: Six 250-ml. to 3000-ml. solutions flasks can be pressure-cleaned per 50-sec. cycle with a high-pressure jet washing principle which removes soils without injury to solutions containers. Output of the washer, ranging from 300 to 360 flasks per hour, meets the fluids-flasking needs of the 100 to 400 bed hospital. *The Macbick Co., Dept. H21, 243 Broadway at Windsor, Cambridge, Mass.*



Electrosectilis (21F-4)

Manufacturer's description: Weighing just 77 lbs. and measuring 1.9 cu. ft., this UL-approved unit can be suspended from the ceiling, mounted on the wall, or used on a mobile cabinet. The electrosectilis features a completely rectified four-tube cutting circuit, with reserve for any electrosurgical technique and a completely damped coagulation circuit, which permits precise coagulation in every power range. A

▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

- _____ Fire door (21F-1)
- _____ Intensive care beds (21F-2)
- _____ Flask washer (21F-3)
- _____ Electrosectilis (21F-4)
- _____ Disposable foot printer (21F-5)
- _____ Dishwasher (21F-6)
- _____ X-ray table (21F-7)
- _____ Disposable culture tubes (21F-8)
- _____ Prep set and sterile catheterization set (21F-9)
- _____ Wall washing machine (21F-10)
- _____ Explosion-proof receptacle and plug (21F-11)
- _____ Storage refrigerator (21F-12)
- _____ Bedpan liner (21F-13)
- _____ Patient gown (21F-14)
- _____ Cold water glass washing concentrate (21F-15)
- _____ Electrode monitors (21F-16)

PRODUCT LITERATURE

- _____ Electric food cart (21FL-1)
- _____ Electron microscopes (21FL-2)
- _____ Glassware washers and instruments (21FL-3)
- _____ Spectroscopy (21FL-4)

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

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How the Airkem Program gets to the heart of the problem of Environmental Health in Hospitals

There's no mystery about it. The Airkem Program does all the jobs that have to be done. It cleans all surfaces. It disinfects – reduces cross-infection. It kills insects – every kind. And it counteracts odors, even the most obnoxious ones, without adding heavy perfumes or chemical smells. And all this while actually cutting down the work-load of your maintenance staff, since Airkem combines two or even three functions in one housekeeping operation!

This is the only complete program of basic hospital sanitation maintenance. Procedures are simple—all you do is insist that the indicated Airkem products are used in their proper places in the hospital.

Airkem matches a treatment to each air space, each odor problem, each sanitation maintenance task – walls and floors, rest rooms, laboratories, kitchens – wards, operating rooms, corridors, elevators – and produces a clean, odorless, agreeable and healthful environment for patients, visitors and staff. Inquire!

See opposite column for one specific Airkem benefit ▶

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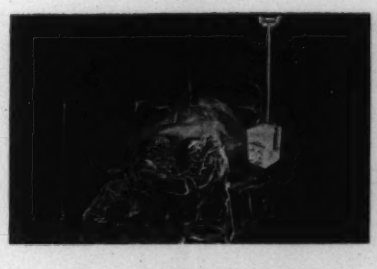
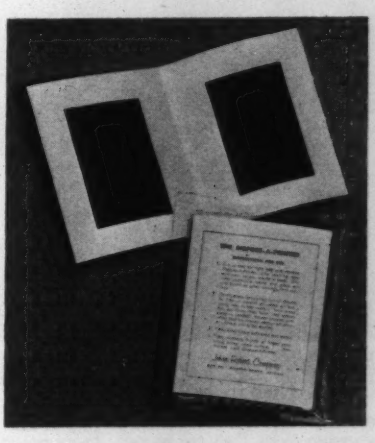


line of accessories, including an explosion-proof footswitch, is also available. *The Birtcher Corp., Dept. H21, 4371 Valley Blvd., Los Angeles 32.*

Disposable foot printer (21F-5)

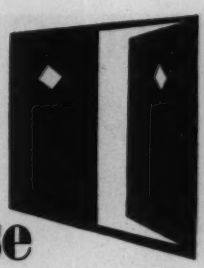
Manufacturer's description: This printer takes permanent, newborn foot or palm prints on regular chart forms, guards against the possibility of cross-infection and reduces nurs-



ing time. Sealed in an airtight plastic bag until ready for use, the printer provides a fine even film of a special formula ink that is completely harmless to a baby's delicate skin. *Johns Robert Co., Dept. H21, Box 34, Morton Grove, Ill.*

Dishwasher (21F-6)

Manufacturer's description: Incorporated in this commercial dishwasher is a 3 ft., 2 in. loading height equipped with inverted polypropylene cradles that hold dishes and trays in a nearly vertical position. Capable of handling up to 13,000 dishes an hour, this model provides an automatic conveyor which permits dishes to be placed in the machine from either the right or left side. A removable scrap drawer at the input of the three-cycle machine aids in eliminating the need for complete prescraping of dishes. An



No Excuse for Health Hazards in Kitchen or food-serving areas!

Foods and utensils are not the only sources of kitchen contamination. Every surface, every wall and floor, every garbage can, every food-storage and food-serving area must be kept free from health-hazards. How?

Two Airkem products provide special safeguards for all these danger spots. One of them, Airkem A-3, searches out dirt and grime and dissolves them, leaves surfaces spotlessly clean. At the same time it disinfects everything it touches. It counteracts odors, too, without adding a heavy perfume or chemical smell – and creates an air-freshened effect. The other Airkem product, an odor-controlled non-toxic insecticide, actually brings insects out of the crannies where they hide and breed, and kills them in the open, where they can be seen and quickly removed.

There is really no excuse for an unsafe kitchen, pantry, cafeteria, or any space in the hospital where food is stored, prepared or served. Daily use of these two Airkem products adds nothing to the work-burden, nothing to the cost. They merely replace products currently required. Ask your nearby Airkem representative!

FREE!

16 oz. can Airkem odor-controlled non-toxic insecticide. (Regular $2.05 value.) Mail this coupon today!

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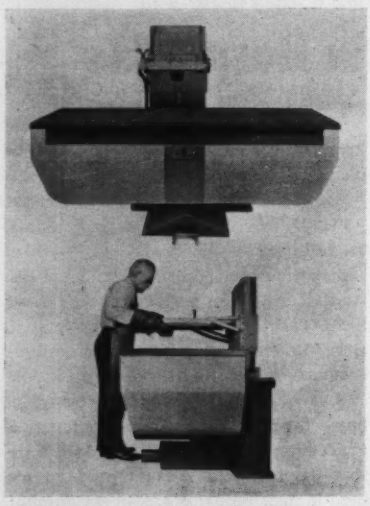
automatic cut-off plate stops the conveyor when the dishes have not been removed and the couplings make all prewash, wash and rinse jets readily accessible for cleaning. *The Jackson Products Co., Dept. H21, Tampa, Fla.*

X-ray table (21F-7)

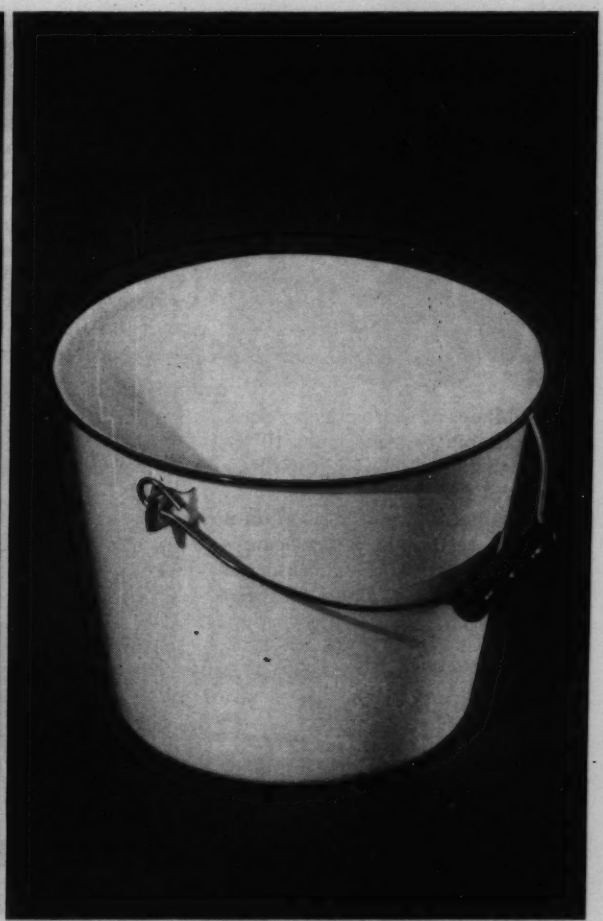
Manufacturer's description: This heavy-duty, radiographic-fluoroscopic spot film table has no front leg and



includes a fluoroscopic collimator, magnetic locks and standard controls. The table operates on a single fulcrum, with a completely enclosed body and automatic bucky slot cover. *Standard X-Ray Co., Dept. H21, 1932 N. Burling St., Chicago 14.*

Disposable culture tubes (21F-8)

Manufacturer's description: These disposable culture tubes assist in eliminating the need for cleaning, handling and storing of conventional



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Wescodyne improves upon, and eliminates the need for, a wide variety of products. Its strong detergent action combines cleaning and disinfecting in one step.

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tubes. Made of borosilicate glass and available in sizes from 10 by 75 mm. to 25 by 150 mm., the tubes are useful for tissue culture work, water sampling and clinical and biological testing in pharmaceutical and public health laboratories. Minimum orders of 25,000. *Corning Glass Works, Dept. H21, Corning, N.Y.*

Prep set and Sterile catheterization set (21F-9)
Manufacturer's description: This line of disposables involving mass daily routines assures patient safety by reducing danger of cross infection. In addition, complete assembly of all necessary items for catheterization or prepping of one patient makes the kits not only convenient,

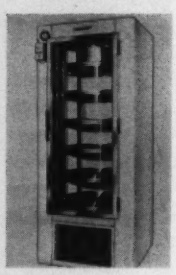
but readily available for immediate use and also simplifies storage problems. *Davol Rubber Co., Dept. H21, Providence, R.I.*

Wall washing machine (21F-10)
Manufacturer's description: This wall washer consists of caster-base twin tanks, built-in hand pump, two 10 ft. connecting hoses and two lightweight 6 x 12 in. aluminum trowels. One tank holds a washing fluid, and a second tank contains fresh rinse water. Air pressure feeds cleaning solution and clear water to the cloth covered trowels. The total weight of the washer is 37 lbs., and the unit is equipped with a washing fluid concentrate which is

available in qts. or 1, 5, 15, 30 and 55 gal. drums. *American Floor Machine Co., Dept. H21, Toledo 3, Ohio.*

Explosion-proof receptacle and plug (21F-11)
Manufacturer's description: Used in combination with a washable, watertight plug, this explosion-proof, three-wire receptacle combines the hospital feature of asepsis with the extra protection of a grounded, keyed and flame-tight electrical receptacle. A pressure-expanded rubber grommet forms a waterproof seal at the cord entrance, allowing the plug to be washed without dismantling and rewiring. *Crouse-Hinds Co., Dept. H21, Syracuse 1, N.Y.*

Storage refrigerator (21F-12)
Manufacturer's description: Offering a temperature control for blood storage, an automatic safety alarm system and an audio and visual alarm in case the temperature gets above or below the proper units, this storage refrigerator also provides an outside thermometer for visual check, a seven-day temperature recorder and an interior finish of white baked on enamel for sanitation and cleanliness. *Uniflow Mfg. Co., Dept. H21, Kold Draft Div., Erie, Pa.*



Bedpan liner (21F-13)
Manufacturer's description: Made of special wet strength paper, and pear shaped to fit any size bedpan, this liner does not permit contents to stick to the bottom of the pan and slips easily out of the bedpan into the toilet. The liners are available

in pads of 96, 10 pads to a carton, with a wall dispenser that releases one liner at a time by push-button operation. *E. J. Huber & Co., Dept. H21, P.O. Box 83, Park Ridge, Ill.*

Patient gown (21F-14)
Manufacturer's description: Provided with snap fasteners, which aid in eliminating the revealing features found in outdated hospital gowns, this garment can be easily laundered and is not affected by laundry

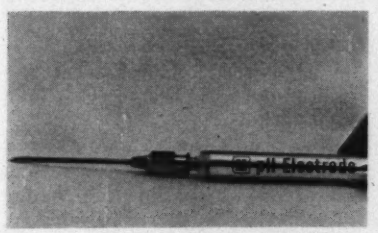
bleaches and chemicals. The stainless steel, snap fasteners make it possible to adjust the gown to almost any size. *Scovill Mfg. Co., Dept. H21, Waterbury, Conn.*

Cold water glass washing concentrate (21F-15)

Manufacturer's description: Available in pint and one-half gallon bottles, this liquid bactericidal detergent for cold water glass washing and food process sanitation cleans and sanitizes in one operation without heat or hot water. Disinfecting action is provided by chemically bound iodine built into the detergent. Instructions are printed upside-down for easy readability when bottle is in the machine reservoir. *DuBois Chemicals, Inc., Dept. H21, Broadway at 7th, Cincinnati 2.*

Electrode monitors (21F-16)

Manufacturer's description: This detector allows measurement of arterial blood pH in a living organism for up to six hours without the use of anticoagulants. The device, which



incorporates two electrodes within the hypodermic needle and syringe, is for use on patients undergoing surgery to determine the amount of carbon dioxide in the bloodstream. *Minneapolis-Honeywell Regulator Co., Dept. H21, Minneapolis, Minn.*

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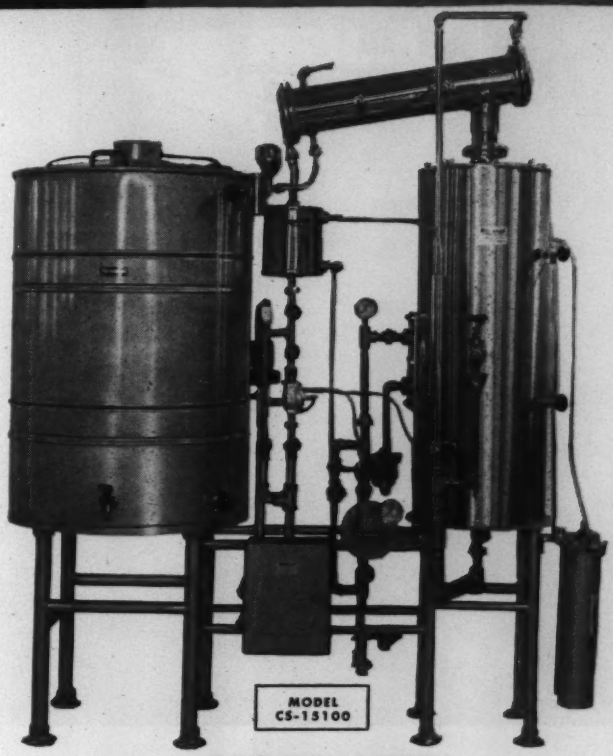

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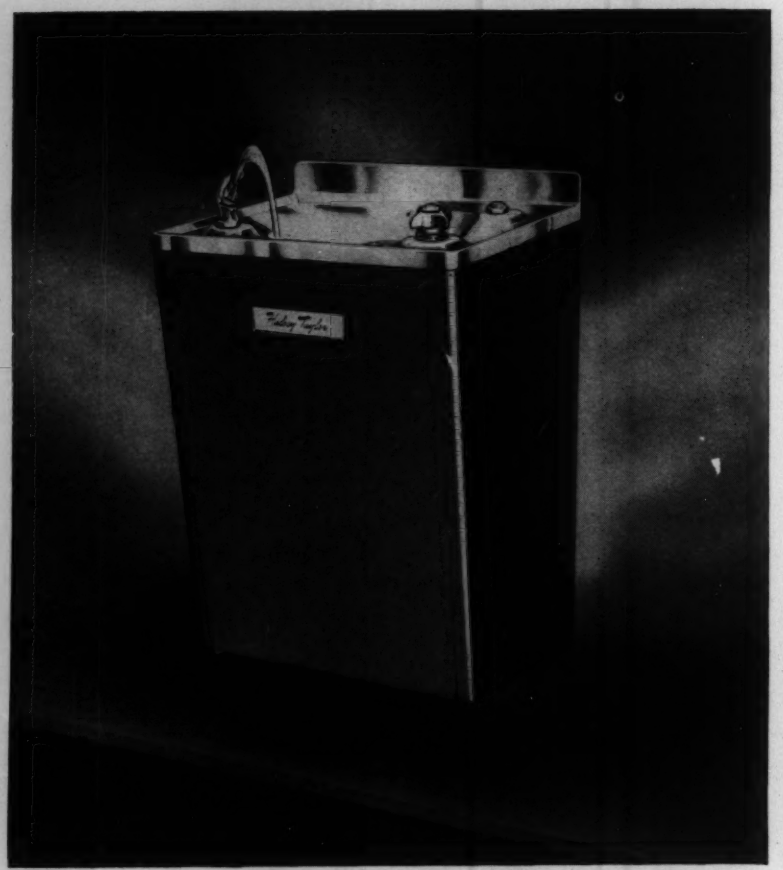

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product literature

SEE COUPON PAGE 88

Electric food cart (21FL-1)—Continuous air recirculation is one of the features outlined of an electric food cart in this four-page pamphlet. Two interior fans, electrically precooled and preheated, circulate hot and cold air in respective compartments; when the cart is unplugged, self-rechargeable batteries take over fan operation, which continues the constant movement of air within the compartments. Holding temperatures, ball-bearing rubber wheels and a protective rubber bumper are also incorporated in the cart. *Southern Equipment Co., Dept. H21, 4550 Gustine Ave., St. Louis 16.*

Electron microscopes (21FL-2)—Illustrated and described in this 24-page booklet are a complete line of electron microscopes, plus other analytical instruments. One section of the booklet provides pertinent data regarding prices, warranties, installation procedures, etc. *Fisher Scientific Co., Dept. H21, 711 Forbes Ave., Pittsburgh 19, Pa.*

Glassware washers and instruments (21FL-3)—Fourteen fliers, each one describing individual glassware items and laboratory apparatus, are contained in this 8½ x 11 in.-folder. Among the instruments described and illustrated are glassware washers, disposable hypodermic needles, washer baskets, glassware detergents, etc. *Heinicke Instruments Co., Dept. H21, 2035 Harding St., Hollywood, Fla.*

Spectroscopy (21FL-4)—This 36-page, pocket-size booklet on ultraviolet, visible and near-infrared spectroscopy contains more than 250 references on absorption, flame, fluorescence, spectroradiometry, reflectance and colorimetry. Also included are references pertaining to spectrophotometry in various industries and areas of research. *Beckman Scientific & Process Instruments Div., Technical Information Dept. H21, Fullerton, Calif.*

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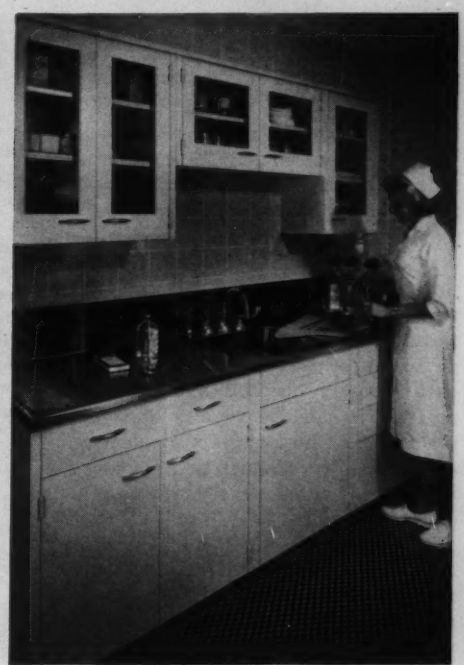

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MANAGING THE ENGINEERING AND MAINTENANCE DEPARTMENT

by HERBERT M. GASKILL

One evidence of successful management of the engineering and maintenance department by the chief engineer, according to the author, is the way he organizes and supervises the routine work of the department, such as periodic checking and semiannual overhauling of equipment. The author describes these basic procedures and suggests how to incorporate them into the total workload of the engineering and maintenance department.

BECAUSE OF THE high cost of replacement in today's market, it is obligatory upon hospital administration to see that the investment in the buildings and equipment of hospitals is protected. Ever since World War II, the U.S. economy has been in an inflationary spiral that has caused difficult problems for those who are charged with keeping hospital budgets in balance. Expensive repairs or replacements, the result of neglect, abuse or misuse, must be avoided to prevent unnecessary hospital expenditures.

It has been pointed out that as high as 50 per cent of the cost of new hospital buildings is for connected electromechanical equipment. Many thousands more dollars are spent for portable machines, such as oxygen tents, floor machines, aspirators, power mowers, snow plows, etc. These items represent a class of equipment that has a rated life of from 10 to 20 years and that must be set up in the budget sinking fund so that replacement funds are available as needed.

LIFE EXPECTANCY FACTORS

There are two factors that interfere with the normal span of life expectancy of any equipment. These are infant mortality and obsolescence. Infant mortality is failure of equipment due to defects in material or workmanship during construction. It, fortunately, is usually covered by a manufacturer's warranty. Obsolescence is what we see when we look at the newer models of equipment that are being displayed on the floor of Convention Hall and compare our older models with them.

Wear and tear is a contributing factor in machine failure. This factor has been always, and will be always, of concern to the manufacturer as well as to the hospital engineering department. The manufacturer has designed the equipment to do a job for a price. You get what you pay for. Higher priced models are usually furnished with dust-proof motors and permanently lubricated bearings, but whatever model you get, there are specific items of service required to keep the machine on the job. These instructions are in the brochure that comes with the equipment.

This service information should be typed on a file card, together with the date of purchase, cost, rated life, nameplate data, cost of repairs and belt sizes. Whenever a serviceman is in the hospital, the hospital engineer should find out what the weak points of the equipment are and what spare parts should be kept in stock to prevent lengthy shutdowns. This information should also be typed on these cards, filed in the engineer's office, and helps to single out equipment that requires more than the normal amount of maintenance.

The service requirements for each machine should be typed and posted by each machine so that the service man can check to see that every oil cup is filled, strainers are cleaned, belts are adjusted, etc. The service man should then date and initial a shipping tag so that supervisory personnel spot-checking these tags on the equipment will make certain that proper maintenance is being performed. Incidentally, the preventive maintenance mechanic is the only man who should go around with a chip on his shoulder; he should look for impending trouble and prevent it by taking the necessary preventive measures. During these routine inspections, if work beyond the scope of servicing is found to be needed, this information should be relayed to the chief engineer's office for immediate scheduling.

In this manner, hospital engineers can keep the operating efficiency as near to 100 per cent as possible. The hospital will be able to function more smoothly because all the component parts that make a hospital click are performing the work for which they were purchased.

On the other hand, equipment that is out of order costs additional overhead because it is not

Herbert M. Gaskill is chief engineer, Atlantic City (N.J.) Hospital. This paper is based on a presentation at the 1961 annual meeting of the American Hospital Association.

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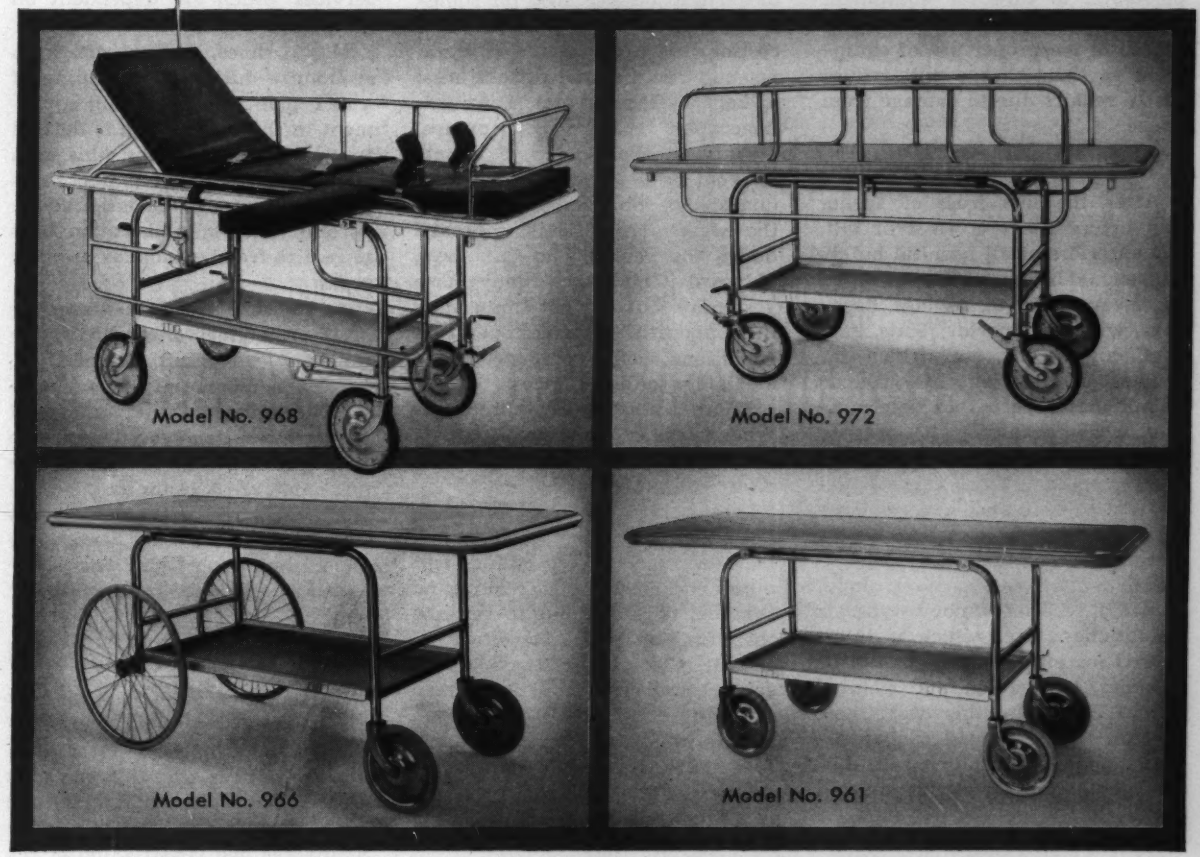

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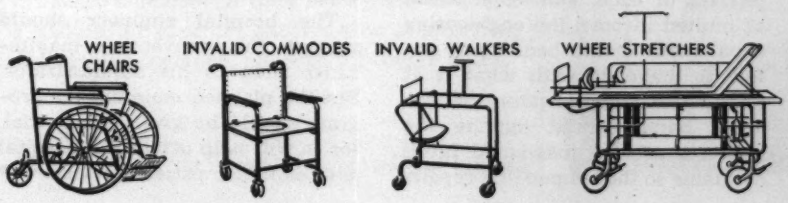

THE GENDRON WHEEL COMPANY
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producing any labor-saving work for the hospital. This is where a saving can be realized if the engineer can inspire his maintenance personnel to care for equipment properly. The instruction of all personnel in the proper use of equipment in their charge will reduce costly repairs due to damage from abuse.

SEMIANNUAL INSPECTIONS

After the last frost of spring and before the first frost of fall, the exteriors of all hospital buildings should be thoroughly inspected to discover roofing, copings, flashings, windows, mortar joints, gutters, downspouts, etc., which are in need of attention. The grounds should be inspected to determine the work necessary to prepare them for the coming summer or winter season. This work should be scheduled immediately so that the damage can be kept to a minimum.

Equipment, such as snow plows, mowers, screens, window-type air conditioners, etc., which is to be stored for either season should be cleaned, overhauled and painted immediately. In this way, new parts that are needed can be ordered and installed during the lay-up period, and the equipment will be ready for use when it is needed for service again.

SCHEDULING REPAIRS

Boiler room equipment should be scheduled for cleaning and inspection during the summer months so that any repairs can be made well before the approach of the heating season. Conversely, the air-conditioning equipment should be overhauled during the winter months. The chiller, evaporator and condenser should be completely gone over and then drained and refilled with fresh oil and treated water to reduce to a minimum any corrosive action during the lay-up period.

The laundry of the modern hospital has thousands of dollars worth of equipment that should be maintained so that many years of service beyond its "rated" life span can be realized. If the laundry manager as well as all other personnel who are near operating machinery would report immediately any unusual noise or malfunction, many time-consuming and costly shutdowns could be avoided.

Every nook and cranny in the modern hospital is used for something, and the machinery space, costing the same amount to build per cubic foot as the patient area, is kept to a minimum. Fans, refrigeration compressors, pumps, etc., are tucked away in closets or what have you, and left to run unattended. So many times when the engineer investigates a breakdown, the person who calls says, "I heard it making a funny noise yesterday, but did not think anything about it." Unusual operating conditions should be reported immediately to the engineer.

There is a happy medium to this type of service, however. It is possible to go overboard and pass the point of diminishing return by spending more than can be saved. To meet this problem, some manufacturers are making motors and other equipment that require no service. It is cheaper to replace these fractional horse power motors than it is to maintain service. The card record system helps to keep the cost of service under control so that the proper financial return is made for the cost of the service rendered. The rising cost of replacement demands that we get the most production out of every piece of equipment in the hospital.

The operation of a plan of this kind requires clerical assistance in the engineering and maintenance departments. The clerk's job in the engineering department of a large hospital is a full-time job. In a smaller hospital, the clerk could also serve in the stockroom of the maintenance shop and thus have firsthand knowledge of the supplies being issued and those on hand.

MUTUAL UNDERSTANDING

Cooperation between the administrator and the chief engineer must be based on a mutual understanding of the problems and objectives of each. During a period of limited income, the engineering department should bend every effort to make do with what is at hand. The administrator, on the other hand, should apprise the engineer of any unassigned funds available so that impending repairs or improvements can be made. Any engineer worthy of his title can make intelligent suggestions for the improvement of patient services which are dependent on mechanical equipment.

Many times, in an effort to economize during the planning of a new plant, the recording equipment in the boiler room is deleted from the contract. But this is a false economy. The boiler room chimney can cost the hospital the "profits" that administration tries to realize from economies in other areas.

At the semiannual institutes for hospital engineers conducted by the American Hospital Association, faculty members have been showing the engineers the advantages of planned maintenance. Those who have inaugurated a preventive maintenance program in their departments have been able to prove its merits. On the other hand, some have been denied the manpower necessary to get the program under way.

HOW MANY EMPLOYEES?

The question often arises of how many engineering department employees there should be for a given number of beds. The answer varies with each hospital, of course, and depends on many variables, such as the age and construction of the buildings, extent of mechanization and other factors.

But a good rule of thumb on this point for any hospital is:

If the hospital is in such condition that the engineer never needs to be concerned about a breakdown, or if he can welcome a tour of inspection by an engineer from a neighboring hospital, then that department probably has an adequate staff. If there are dripping pipes, areas in need of painting, machinery out of service, men frequently working overtime to restore service, or a backlog of work to be done, the department needs more employees or needs to make more efficient use of those it has.

The hospital engineer should suggest this preventive maintenance plan to his administrator. But the planned maintenance program should be given a fair trial, for it will help attain the hospital goal of better patient service. ■

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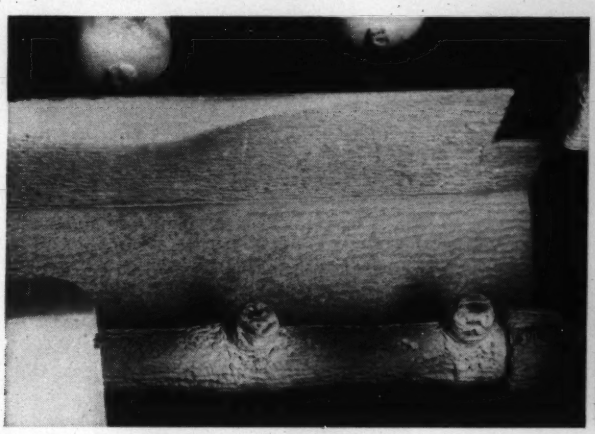
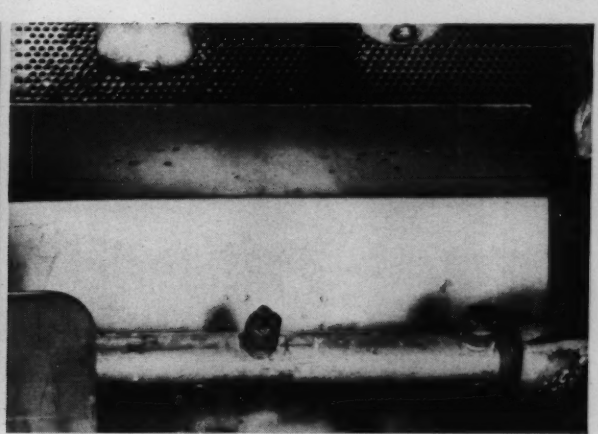


How lime can build up in a dishmachine



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book reviews

Services to unmarried parents

also:
Legal aspects of anesthesiology
Planning health facilities
Medical record bibliography

THE ROLE OF HOSPITALS IN SERVICES TO UNMARRIED PARENTS AND IN ADOPTIONS. American Hospital Association. Chicago, the Association, 1961. 11 pp. 35 cents.

This is an inclusive statement of services within the hospital which are essential to understanding care of unmarried parents and those about to give their infants for adoption.

The title may disturb some who feel that various professional groups in the hospital have a role rather than the hospital itself. Nevertheless, this pamphlet gives to all employees of a hospital an insight into services essential to the unmarried parent.

In this day when adoptions are increasing so much, this statement, together with the specific state regulation, should be read by all who have occasion to have contact with unmarried pregnant women in the hospital setting.—HILDA H. KROEGER, M.D., *administrator, Elizabeth Steel Magee Hospital, Pittsburgh.*

Legal aspects of anesthesiology

ANESTHESIA AND THE LAW. Carl Erwin Wasmuth. Springfield, Ill., Thomas, 1961. 105 pp. $4.50.

Dr. Wasmuth is an anesthesiologist and a lawyer. This happy combination allows him to effectively explain the law to medically oriented readers. To a lesser extent, lawyers may make reference to this work for a technical explanation of anesthesiology.

The author has reviewed the basic principles of law which would affect the administration of anesthetics, whether by physicians or nurses. He has admirably integrated scientific subject matter with its legal implications. The book, although only 102 pages long, considers the medical-legal problems related to spinal anesthesia, operating room explosions and broken teeth. It also includes an original treatise on legal aspects of cardiac arrest. One chapter explains the legal relationships between the surgeon and the anesthesiologist and between the surgeon and the nurse anesthetist.

In a section on disclosure of medical records, Dr. Wasmuth takes a permissive view, which is consistent with the most recent thinking in this field. The courts and the legislators, as well as medical-legal specialists, have been concluding of

meeting a widespread professional demand

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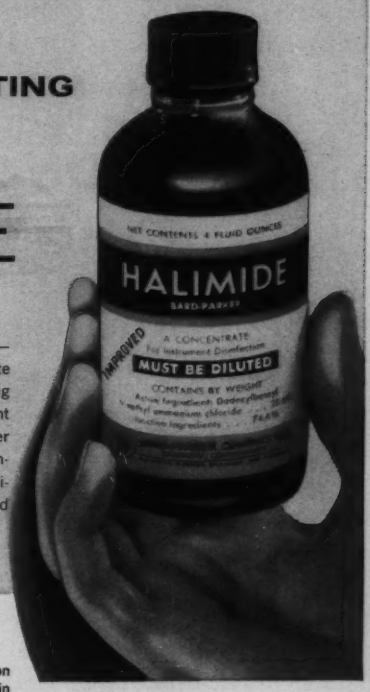

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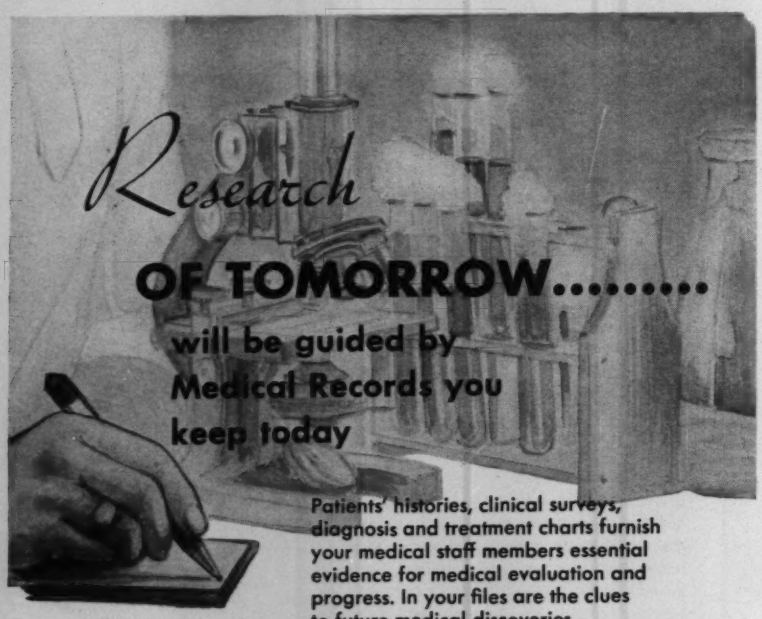
late that there are few risks in disclosure of medical record information to persons having a legitimate interest in it.

Some of the chapters appeared earlier as individual articles and, for this reason, there is less editorial unity in the work than might be desired. Because the book is not likely to be read at one sitting, however, this problem is not significant.

The brevity of the work eliminated consideration of such related topics as the so-called "corporate practice of medicine" when anesthesiologists are engaged by hospitals, the ethical implications of anesthesiologists serving on salary, the practical problems of contractual relationships between anesthesiologists and hospitals or anesthesiologists and their associates. There is no discussion of the responsibility of the anesthesiologist as a member of a hospital medical staff, or the legal and financial aspects of his relationship to his partnership or his hospital, especially with regard to retirement plans, annuities or social security coverage. The author does cover problems of patient's consent, discusses the ingredients of negligence and the hospital's responsibility for the anesthesiologist.

For the hospital administrator, anesthesiologist, nurse anesthetist, or anyone else interested in the peculiar relationship between anesthesia and law, this book will be illuminating and useful.—ARTHUR H. BERNSTEIN, *staff attorney, American Hospital Association.*



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The F. W. Dodge Corp., New York, has recently published *Hospitals, Clinics and Health Centers,* a collection of articles on planning health facilities which appeared originally in the journal, *Architectural Record.*

The book is divided into four sections: (1) hospital buildings, (2) special facilities, (3) rehabilitation centers and (4) health centers, physicians' offices and clinics. Architects, hospital administrators and consultants will find the complex problems involved in planning modern hospital buildings adequately covered in this well illustrated publication. The price is $9.75 and the address of the publisher, 119 West 40th St., New York 18.

Medical record bibliography

The Matthews Book Co., 3140 Park Ave., St. Louis 4, Mo., has recently published the 17th volume of *Selected Annotated Bibliographies on Various Phases of Medical Records* by Sister Mary Servatia, director of the Department of Medical Record Library Science at St. Louis University. Annotations for nearly 200 articles from nine major hospital, nursing and medical records journals are arranged in alphabetical order by author. A content index by broad subject and an author index are included.

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● **John Paul Barrett** has been appointed administrator of Syracuse (N.Y.) Memorial Hospital, Inc. Mr. Barrett, a graduate of the program in hospital administration at Emory University, Atlanta, Ga., has been assistant administrator of Memorial Hospital of Chatham County, Savannah, Ga.

MR. BARRETT

MR. CROWDER

MR. DURBIN

● **Dean M. Crowder** has been appointed administrator at Morningside Hospital, Los Angeles, managed by the Lutheran Hospital of Southern California. He comes to his new post from Riviera Community Hospital, Torrance, Calif., where he served as acting administrator on a consulting basis.

Mr. Crowder was previously affiliated with Donald N. Sharp Memorial Community Hospital in San Diego, Calif., as administrative resident and administrative assistant. He is a graduate of Emory University, Atlanta, Ga.

● **Richard L. Durbin** has been appointed a member of the faculty and associate director of the Graduate Program in Hospital Administration of the University of Chicago.

Mr. Durbin received his master's degree from the University of Chicago graduate program in 1955. In 1956 he became the assistant administrator of the City of Memphis (Tenn.) Hospitals. He left that position in 1960 to become assistant administrator at Presbyterian-St. Luke's Hospital, Chicago, Ill.

● **Jerry L. Durr** has been appointed administrator of the Fredericksburg (Tex.) Hospital and Clinic, succeeding the late **Harry O. Davis.** Mr. Durr was formerly medical administrator with the United States Air Force, School of Aerospace Medicine, Brooks Air Force Base, Tex.

● **Jeanette H. Fessenden** has been named administrator of the House of the Holy Comforter, New York. She succeeds **Mary Jane Hutchinson,** who has retired after serving as administrator of the hospital for 14 years.

Miss Fessenden holds a bachelor's degree in business economics from Johns Hopkins, and a master's

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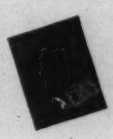

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degree in hospital administration from the University of California.

● **Joan Gilson,** formerly personnel director at the Valley Hospital, has taken up her duties as assistant administrator to Clarice H. McGarry, R.N., administrator.

● **Mary Jane Hutchinson** (see Fessenden item).

● **Kenneth C. Johnson** has been appointed assistant administrator of Yakima Valley Memorial Hospital, Yakima, Wash. Mr. Johnson, a graduate of the University of Minnesota program in hospital administration, served his administrative residency at San Jose (Calif.) Hospital.

● **Jack Kasten** has recently joined the faculty of the Graduate School of Public Health, University of Pittsburgh, as research associate in medical and hospital administration. He was formerly assistant director of the Jewish Memorial Hospital, Boston, and holds a master of public health degree from the University of Michigan.

● **Leo Reich,** administrator of Broadlawns Polk County Hospital, Des Moines, Iowa, has resigned and will accept a new position as administrator of Greene Memorial Hospital, Xenia, Ohio. **Cyril H. Weagle Jr.,** who has been assistant administrator at Broadlawns Polk County Hospital, has been appointed acting administrator. Both men are graduates of Northwestern University.

● **Barry J. Solomon** has been named to the position of assistant administrator at the James Lawrence Kernan Hospital and Industrial School of Maryland for Crippled Children, Inc., Baltimore. Mr. Solomon is a graduate of the Xavier University program in hospital administration.

● **Orel H. Stewart** is the new assistant administrator of Baptist Memorial Hospital, San Antonio, Tex. He has been administrative assistant at Kendrick Memorial Hospital, Abilene, Tex., since 1957.

● **Cyril H. Weagle Jr.** (see Reich item).

Death

Joseph V. Friel, who for more than 20 years directed preparations for the annual AHA Hospital Mart, died on October 3.

MR. FRIEL

Associated with Reber-Friel Co., Philadelphia, Mr. Friel entered the convention management field more than 35 years ago as an electrical contractor. His company branched out into other phases of convention service, such as carpentry, plumbing and decorating, and by 1938, was engaged in full-scale convention management.

During the 1959 Annual Meeting of the American Hospital Association, Mr. Friel was awarded a citation in recognition of distinctive contributions to the hospital field.

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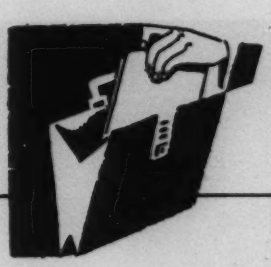

Legal matters of interest to the hospital field prepared by the law department of the American Hospital Association

Blood Error Presumes Negligence

The legal doctrine of *res ipsa loquitur* has been applied to a blood-typing situation. The result is to allow the plaintiff to present a cause of action without need for expert medical testimony. In effect, the burden of persuasion passes to the defendant hospital, a task which is difficult to fulfill.

The expansion of *res ipsa loquitur,* or "the act speaks for itself," to medical cases has resulted in part from the reluctance of physicians to testify against their colleagues in court. The judges (to assure a more fair trial) have recognized that under certain circumstances the occurrence of injury may be presumed to be negligently caused. These would be situations where the defendant has complete control of the instrumentality of harm, the victim was completely innocent and the injury would not have happened unless someone were negligent. In medical incidents, *res ipsa loquitur* was found applicable to operating room injuries where a part of the patient's body, unrelated to the operation, suffered injury and the patient was unconscious and totally helpless in the hands of the operating room staff.

Extension of the doctrine to blood typing is not unexpected, although it assumes that the techniques of blood typing are so foolproof that any error raises a strong presumption of negligence. A plaintiff need bring no physicians or technicians to court to show the negligent nature of the error. The mere existence of a mistake in blood typing presumes malpractice and it is for the defendant to explain away the presumption. This means proving a negative—that one was not negligent—a more demanding project than proving a positive.

In *Redding v. United States,* 13 CCH Negl. Cases 2d 217 (D.C. W.D. Ark., 1961) the suit was brought against the United States by an army officer and his wife. The latter suffered from a technician's error in typing her blood at a military hospital. Suit was brought under the Federal Tort Claims Act and resulted in a verdict awarding $40,000 to the wife for past, present and future physical and mental suffering as well as bodily disfigurement, and $10,000 to the husband for loss of the services, society and companionship of his spouse. Attorney's fees were limited by the court to 20 per cent of the judgment, as compared with the more customary one-third. The doctrine of *res ipsa loquitur,* as described above, was accepted by the court as applicable in this situation.

More Time To Sue Hospitals

In an effort to avoid going to trial, a Colorado hospital sought to adopt the legal status of physicians. Under the state laws, malpractice actions must be brought against doctors and dentists within two years of the date when the cause of action accrues. In this case, the plaintiff waited more than two years, but not long enough to be barred from bringing an ordinary negligence action.

The trial judge read the statute favorably toward the hospital defendant and dismissed the action. The Colorado Supreme Court, however, reinstated the case. It pointed out that a hospital is not "licensed to practice medicine". Hence, the two-year statute of limitations does not apply and the ex-patient may proceed with his suit. *Purcell v. Poor Sisters of St. Francis Seraph,* 13 CCH Negl. Cases 2d 264 (Colo., 1961).

Physician Liable, Not Hospital or Nurse

After his wife died in childbirth, the plaintiff sued the doctor, nurse anesthetist and hospital. The trial resulted in a verdict against the physician, but the other defendants were exonerated. The judge set aside the jury's verdict on the theory that it was inconsistent to hold for two defendants and against the other. He authorized a new trial. The appellate court disagreed, however, and restored the jury's verdict. *Weinstein v. Prostkoff,* 12 CCH Negl. Cases 2d 806 (N.Y. Sup. Ct. App. Div., 1961).

The hospital and nurse contended that death was the result of a rare embolism, which occurred in spite of exercise of standard practice for such a case. The plaintiff claimed that his wife choked to death and offered the testimony of a physician as to methods which the doctor and nurse could have used to avoid fatal consequences. Said the appellate court:

> "Nor can the verdict be deemed inconsistent because it was rendered against the doctor and in favor of the nurse. The jury could have found that the doctor was derelict in matters of judgment which were exclusively his concern, whereas the nurse adequately performed her limited duties without notice to her of asphyxiation. . . . (It) is our opinion that the verdict in favor of the nurse and hospital should not have been set aside."

Here the hospital was bound by the acts of its employee, the nurse anesthetist. If she did not violate the standard of care which she owed to the patient, neither she nor the hospital could be held liable. The attending physician's duty was more exacting and

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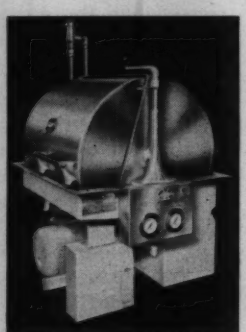

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he was found by the jury to have failed to meet the standard of care applicable to this clinical situation.

All Michigan Hospitals Now Liable

Only a year after lifting charitable immunity, the Supreme Court of Michigan has gone the rest of the way. Sovereign immunity has been discarded by judicial order. Now governmental units, including the state and its political subdivisions, may no longer escape tort liability. Hospitals operated by governmental bodies are as fully exposed to negligence liability as their voluntary nonprofit counterparts.

In its opinion in *Williams v. Detroit,* 30 Law Week 2150, dated September 22, 1961 and written for the majority by Justice Edwards, the court said:

> "From this date forward the judicial doctrine of governmental immunity from ordinary torts no longer exists in Michigan. In this case, we overrule preceding court-made law to the contrary. We eliminate from the case law of Michigan an ancient rule inherited from the days of absolute monarchy which has been productive of great injustice in our courts. By so doing, we join a major trend in this country toward the righting of an age-old wrong."

IS THERE A TREND?

To support its view that a "major trend" exists, the opinion cites cases in California, Illinois and Florida where traditional sovereign immunity has been overturned by judicial decree. Only the California case, however, specifically applies to the state as a defendant. *Muskopf v. Corning Hospital District,* 55 Cal. 2d 211, 359 P. 2d 457 (1961), principle reaffirmed in *Lattin v. Coachella Valley County Water District,* 13 CCH Negl. Cases 2d 238 (Cal. App., 1961). The Illinois case referred to school districts and the Florida litigation concerned municipalities. In neither jurisdiction has a state hospital or instrumentality yet been declared liable for tort liability.

The California legislature recently passed an act which has the effect of placing a two-year moratorium on suits against the state government or its subdivisions. Whether these suits will ultimately be allowed or will be barred depends upon further action of the California legislators. In Michigan, however, any doubts left after the case of *Harrison v. City of Pontiac,* reported in HOSPITALS, J.A.H.A., September 1, 1961, p. 99, are now dissipated. City hospitals have the same exposure to liability as do Michigan's voluntary nonprofit institutions.

The Michigan court might have added that sovereign immunity has been eliminated by statute in New York State. The three justices who dissented to the majority opinion felt that this kind of legislative action is the only appropriate means of adopting sovereign liability for torts. Whether the courts or the legislatures are the motivating vehicles, it appears that a trend indeed has developed. Governmental institutions may anticipate losing their tort immunity in the coming years.

With regard to the economic impact of its decision upon governmental defendants, the Michigan Supreme Court declared:

"Each brief speaks of the crushing weight of negligence awards which might bankrupt a small governmental unit.... (They) avoid mention of public liability insurance as if it were a new and barely tried invention of which the courts could not possibly have knowledge.... In 1961, however, liability insurance is no new and untried device."

LIABILITY OF STATE AIDES

Will governmental officials become liable for the consequences of their official acts and determinations? The court reassures them that "actions or decisions of a legislative, executive or judicial character which are performed within the scope of authority of the governmental body or officer concerned, continue to enjoy freedom from liability." So it would seem that individuals working in governmental hospitals in Michigan will be subject to the same legal responsibility for the consequences of their negligence as has applied in Michigan's voluntary nonprofit hospitals since September 1960, but not more. A New Jersey report involving a state institution confirms this:

"A public officer is not absolved for his private or personal torts. Should he commit a tort in the performance of official duties that are 'discretionary', he would be immune, whereas, if he commits a tort in the performance of duties of a ministerial character, he would be liable for them regardless of good faith."

Kisielewski v. State of New Jersey, 13 CCH Negl. Cases 2d 295 (N.J. Sup. Ct., App. Div., 1961).

Short Hiatus Equals Harrassment

An Illinois court has ruled on whether a physician need be accorded a hearing by the governing board of a district hospital only a few months after losing his appeal for reinstatement on that hospital's staff. Four months after the appellate court turned down his previous plea, a physician again brought suit to compel the district hospital to grant him staff privileges. In the earlier case, privileges were denied after a probationary period expired because the physician lacked professional skill. A full hearing had been conducted in the hospital and, upon review, the court found no violation of procedural rights or of the doctor's legal interests. *Dayan v. Wood River Township Hospital*, 152 N.E. 2d 205 (Ill. App., 1958).

In the latest case, the same court branded the new petition as constituting harrassment of the hospital administration and the staff. The court said that it is for the board to determine whether a reasonable time had elapsed in order to justify another hearing. The opinion relates that the board might also require the applicant to show in advance of any additional hearing that his previous deficiencies have been removed. The evidence of the elimination of prior inadequacies must be something more than the physician's own opinion, the court ruled. *Dayan v. Wood River Township Hospital*, 171 N.E. 2d 675 (Ill. App., 1961).

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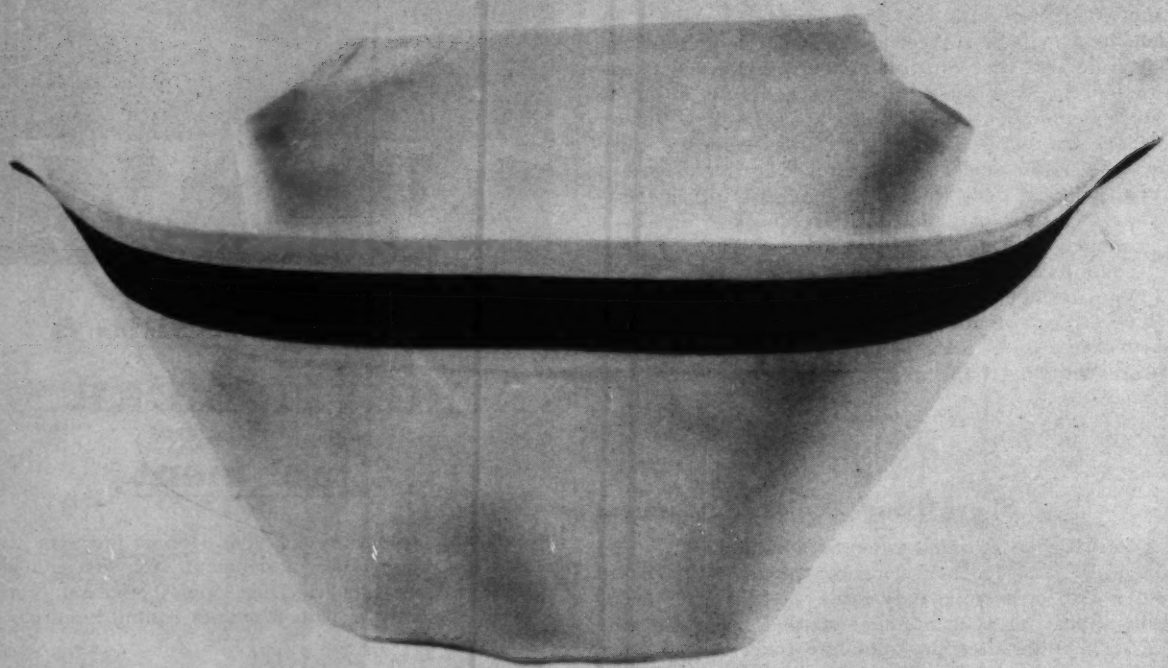

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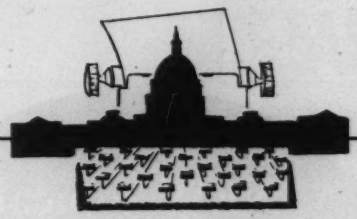

Later Deadline Set for Hospital Research Projects

Dec. 15, 1961, is the deadline for applications for the new health facilities research projects. These are experimental or demonstration construction or equipment projects under the $10 million annual grants program authorized in the Community Health Services and Facilities Act of 1961. The act was signed by President John F. Kennedy on October 5. Consequently, to allow sufficient time for filing of the first applications, the U.S. Public Health Service moved the deadline from November 1 to December 15.

Hospitals are specifically included in the public and private nonprofit institutions eligible for the grants. These are matching grants and the federal share is limited to 66⅔ per cent of the cost of the experimental project. Applications and descriptive material with instructions and specifications should be obtained from the Chief of the Division of Hospital and Medical Facilities, U.S. Public Health Service, Washington 25, D.C.

Drug Bill Hearings Schedule Announced

Hearings on pending amendments to federal drug legislation resumed in mid-October. The bill under consideration is S.1552, which proposes changes in the antitrust, patent and food and drug laws. It was introduced by Sen. Estes Kefauver (D-Tenn.), chairman of the Senate Antitrust and Monopoly Subcommittee, which has been holding intermittent hearings on the bill since early July. Senator Kefauver announced that the antitrust and patent aspects of the proposed legislation would be the subject of two or three days of hearings in mid-October and a subsequent series of subcommittee meetings for two or three days beginning October 31. The next sessions are scheduled to start December 6, when representatives of the pharmaceutical industry will present their views on various phases of the pending bill. The Senate subcommittee hopes to report a measure soon after Congress reconvenes on Jan. 10, 1962.

The Department of Health, Education, and Welfare (HEW) is seeking to improve consumer protection under the Food, Drug and Cosmetic Act. Abraham A. Ribicoff, Secretary of Health, Education, and Welfare, announced in mid-October the appointment of a 16-member Citizens Advisory Committee to make a comprehensive study of the problems involved. He said the committee will make recommendations on the steps HEW and the Food and Drug Administration (FDA) should take to insure adequate protection to citizens in their use of drugs, therapeutic devices, foods, cosmetics and household chemicals, all of which are subject to regulation under laws enforced by the FDA. As pointed out by Secretary Ribicoff, the retail value of such articles moving in interstate commerce is estimated to be more than $100 billion annually.

The HEW Secretary said that the committee will make a new appraisal of consumer protection problems, rather than continue a study made by a similar citizens advisory group in 1955. A major recommendation in the earlier study was a triple to quadruple expansion of the FDA in 5 to 10 years. Since that time the FDA has approximately doubled in size. Secretary Ribicoff said: "Tremendous developments in the fields of science and technology daily present new challenges to those charged with safeguarding the consumer. It is time for another group of responsible citizens to take a new look at what the federal government, through the Food and Drug Administration, should do to assure consumers of truly adequate protection."

The chairman of the new committee is George Y. Harvey, lecturer in political science and consultant in community development at the University of Missouri. The members include representatives of medical education, the pharmaceutical industry, labor and the home economics field.

$20 Million Committed for Aged Housing

More than $20.6 million had been committed for loans for rental housing projects for the aged by mid-October. The total covered 31 projects approved by the Housing and Home Finance Agency (HHFA). The program started in mid-1960 and now has an authorized ceiling of $125 million, of which $80 million has been appropriated by Congress. Legislation enacted by the 1961 Congress extended eligibility for participation in the program. Previously, loans could be made only to private nonprofit corporations for construction or renovation of rental housing projects for senior citizens. Now consumer cooperatives and public bodies or agencies are also eligible.

No hospital or hospital-affiliated groups were among the recipients of loans authorized by mid-October. A number of the approved rental projects specifically include health facilities or have been planned in coordination with or adjacent to nursing homes and hospitals. A project in Concordia, Mo., calls for simultaneous construction of the rental structure and an adjacent nursing home, with the latter financed with Hill-Burton funds.

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Description: Cordran cream and ointment are new corticosteroid preparations for topical use. Each Gm. contains 0.5 mg. Cordran.

Cordran-N cream and ointment combine Cordran and a safe, effective wide-spectrum antibiotic, neomycin. Each Gm. contains 0.5 mg. Cordran and 5 mg. neomycin sulfate (equivalent to 3.5 mg. base).

The cream base is composed of stearic acid, cetyl alcohol, liquid petrolatum, polyoxyl 40 stearate, ethyl parahydroxybenzoate, glycerin, and purified water. The ointment base is composed of white beeswax, cetyl alcohol, sorbitan sesquioleate, and white petrolatum.

Side-Effects: No side-effects have been reported to date from the use of either the cream or ointment forms of Cordran and Cordran-N.

Contraindications and Precautions: Cordran and Cordran-N should not be used in the presence of tuberculosis of the skin, nor should they be used in the eyes.

If secondary bacterial infections of the skin are present prior to the use of Cordran, they should be treated also with appropriate anti-infective measures. If the infection present before the application of Cordran or Cordran-N, or developing during its use, does not respond promptly, discontinue the preparation until the infection has been adequately controlled.

Patients with superficial fungus or yeast infections should be treated with additional appropriate methods and must be under constant medical observation.

Although sensitivity has not been reported, a few individuals may be sensitive to these preparations. If any reaction indicating sensitivity is observed, discontinue the use of the product. If a patient has a proved idiosyncrasy to neomycin, another antibiotic may be used along with Cordran.

Since use of antibiotic agents may cause overgrowth of nonsusceptible organisms, constant observation of the patient is essential.

Administration and Dosage: Cream—For moist, weeping lesions. Rub a small quantity of cream gently into the affected areas two or three times daily. Vigorous application is not necessary and may damage the skin.

Ointment—For dry, scaly lesions. Apply a small quantity of ointment as a thin film to the affected areas two or three times daily.

How Supplied: All product forms are supplied in 7.5 and 15-Gm. tubes.

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IN CHICAGO—

Enrollment, Benefits, Utilization Discussed At Congress On Prepaid Health Insurance

Representatives of prepaid health insurance organizations and of various groups in the health field convened at Chicago's Sheraton-Chicago Hotel on October 14 and 15 for the 2nd National Congress on Prepaid Health Insurance.

Sponsored by the American Medical Association Council on Medical Service, the congress attracted some 225 representatives of government, commercial insurance companies, Blue Cross and Blue Shield, group practice plans, AFL-CIO, industry and other professional and trade organizations.

The purpose of the meeting was to consider four basic problems of prepaid health insurance:

1. Enrolling employee groups and association groups, and the inherent differences between individual and group enrollment problems.

2. Expanding scope of benefits, including the extent of coverage, use of deductibles and coinsurance.

3. Proper use of coverage in terms of utilization and fee review committees, audit committees, insurance information committees, grievance committees and other mechanisms for assuring proper use of coverage.

4. State regulation and pertinent studies of insurance and prepayment, actions and recommendations of state regulatory agencies and what these mean to voluntary health insurance.

PROBLEMS OF ENROLLMENT

William H. Horton, M.D., executive director, Connecticut Medical Services (Blue Shield), declared that the major objective of Blue Shield was to make the benefits of prepaid medical care available to all people, not as merely a business venture, but as a means by which the medical profession may be free for voluntary development of its maximum effectiveness. "One's attitude toward either community rating or experience rating," he said, "is determined largely by one's viewpoint: that is, whether one is primarily interested in the business aspects of medical care or one is concerned with the protection of the voluntary practice of medicine."

William R. Breher, supervisor, employee benefits, industrial relations staff, Ford Motor Company, stated that there was a great need for Blue Cross and Blue Shield to establish rates on a broad base of community need. He pointed to the community rating era of the two plans as having produced the greatest increase in enrollment.

According to T. Eric Reynolds, M.D., member of the committee on insurance and prepayment plans, AMA council on medical services, enrollment impinges on the physician in three ways: It affects the quality of medical care; it affects the physician's income, and it indirectly affects the physician's overhead expenses. He said that the problem that physicians and patients with health insurance share is the uncertainty as to what benefits the patient actually has. To solve this problem, Dr. Reynolds suggested the promulgation of "an optimum contract subject to rate modification by variable coinsurance provisions at the group's option."

EXPANDING SCOPE OF BENEFITS

Henry S. Blake, M.D., chairman of the board, National Association of Blue Shield Plans, reviewed Blue Shield's past record in expansion of benefits, pointing to the development of extended forms of coverage by the Plans. He acknowledged criticisms of Blue Shield for going too slowly, but pointed to the need for sound, carefully developed programs.

Morton D. Miller, vice president and associate actuary, the Equitable Life Assurance Society of the United States, stressed that coinsurance and deductibles were needed to control overuse of benefits.

Taking the viewpoint of management on the same question, Ralph Rothstein, director, industrial relations, Minnesota Mining and Manufacturing Company, said that individuals should have broad and balanced coverage for both in and out of hospital expenses; that the subscriber to health insurance should keep before him constantly the fact that he is receiving value in the form of protection against illness expense, and that the insurance plan should be flexible enough to provide approximately the same level of benefits regardless of variation in local medical practice. He also said that duplication of benefits is unsound and should be discouraged.

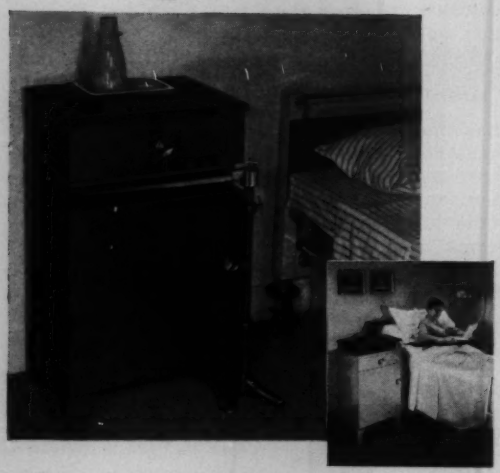
Ross V. Taylor, M.D., Jackson, Mich., said that unnecessary demands on the physician must be curtailed. He emphasized that the expansion of health insurance benefits will depend to a major degree upon the availability of physicians and their combined abilities to provide medical care.

Costs and the availability of additional services were among the hurdles to expansion outlined by Arthur Weissmann, director of medical economics, Kaiser Foundation Health Plan, San Francisco. Broadened benefits will not necessarily increase the cost of prepayment, he said. To the extent that appropriate use of services is stimulated, he continued, broadened benefits may reduce the aggregate cost of prepayment.

Carl R. Ackerman, M.D., chairman of the board, United Medical Services, Inc. (Blue Shield), New York City, suggested the appointment of three committees of county medical societies: A grievance committee to deal with breaches of law and ethics; a review committee to study the patterns of practice within a given area, and an insurance committee to review health insurance programs affecting the area concerned and to act as liaison with insurance organizations. To insure the success of these committees, he suggested, adequate authority should be assigned to the medical society committees and that personnel and funds be allocated to carry forward the work of the committees.

Matthew Marshall Jr., M.D., Pittsburgh, reported that results of the work of utilization review committees in his area included improvement of the basis upon which claims are judged; better use of beds; improved medical records, and a recognition of mutual responsibility by all parties concerned. He said that "long-term medical cost control requires that

Valette®—P9321, etc. Valette occupies only 4 square feet of floor space, yet provides individual wardrobe for shoes, over-night case, etc. Available in a choice of models including two with retractable over-bed leaf. All models have wardrobe space with hanger rod, 2 double hooks, etc. Choice of beautiful finishes. (*Pat. Pending*)



Queen of Angels Bedside Cabinet—Hi-Low Model—P9317. Has large, roomy drawer; large compartment for utensils; over-bed leaf swings out of retracted position over the bed. Adjusts vertically from high of 50″ to low of 29½″.

Queen of Angels Bedside Cabinet—Standard Model—P9315 (inset). Over-bed leaf has range of height adjustment suitable only to standard hospital beds.

Amp Electric Bed—P9730. Embodies 15 innovations, representing major departures from conventional beds. Provides total automation. Mechanism completely enclosed; no springs—easy to clean. A higher high; a lower low. Patient can make all adjustments or be denied control. Takes all accessories. Choice of finishes.

TRENDS In Patient Room Furnishings

Save Valuable Floor Space—Achieve New and Distinctive Effects in Interior Design.

Hospitals, like people, assume a certain distinctive character or individuality which can be favorable or unfavorable from the viewpoint of the public.

Many hospitals have found that a slightly out-of-focus image can be corrected by *creative* equipment selection and arrangement, embodying the best principles of modern interior design.

Custom-designing An Impression. The most lasting memories impressed upon the mind of patient or public are visual. The apparent size of the room, its drapes, furniture, walls, etc. These are things that can be controlled from start to finish, as many hospitals have learned; and, by this means, the exact impression they wish to make upon public, patient and their own staff alike is likewise controlled.

Equipment—Important Element of Design. Equipment selection and arrangement is the most important means of creating hospital interiors of outstanding distinction and merit. Our new Valette, for example, is often selected because it eliminates the old wardrobe that occupied so much floor space, as well as the large, old-fashioned dresser. The patient is both amazed and pleased that his entire belongings can be kept together at his bedside along with the usual hospital utensils, etc.

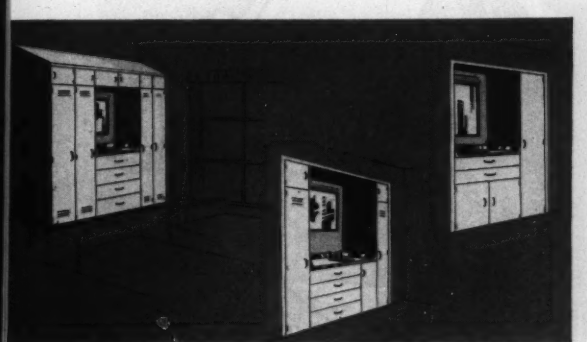
The Queen of Angels Hi-Low Bedside Cabinet is another excellent example of equipment designed to save space, yet embody the functional convenience that nurses and patients appreciate so much.

Color and Texture. Color and Texture are the most important tools used by the interior designer in establishing the all-important esthetic values which are receiving more and more attention in modern planning. These are inescapable, and must be dealt with wherever they are found in equipment, floor, walls, drapes and accessory items. They can be changed or altered without limit, but decisions must be made.

Selection and arrangement of colors and textures should be left to those experienced in this field, if the most desirable results are to be expected. This is, in fact, a specialized field in itself.

Let Aloe Help You Plan. Aloe Equipment Planning and Interior Design Department is staffed by consultants experienced in all aspects of interior design and are available to assist you at all times. Our planning staff is prepared to suggest equipment lists and work directly with you in achieving custom-type interiors suitable to your hospital alone.

Write or see your Aloe Representative for complete details.



Eliminate loose furniture and old-fashioned sinks with these custom-built wardrobes and casework units, which combine wardrobe, vanity, sink, dresser, lockers and linen storage. May be recessed in the wall. Available for private, semi-private, three- or four-bed rooms. Select any part or complete facilities.

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each party develop a tolerant willingness to study the problem and assume his proper responsibility."

Among the remedies for over-utilization outlined by Floyd L. Boddicker, manager, Hercules Powder Company, Hopewell, Va., was to encourage wider use of credentials committees to insure ethical and well-qualified medical staffs, utilization committees to prevent overuse, and state medical care coordinating committees for over-all control of quantity, quality and type of facilities.

John F. Tomayko, director, insurance pension and unemployment benefits department, United Steelworkers of America, Pittsburgh, said, "If we expect to preserve and expand our voluntary system of health insurance, the medical profession must accept the principle that proper use of insurance coverage means, among other things, making a reality out of the word 'prepayment', and that the medical profession's continued abuse of the privilege of overcharging can bring about an early collapse of this system."

"One of the most notable developments of medical economics in the past five years is that of various hospital studies being conducted on the state level," said Walter J. McNerney, president of the National Blue Cross Association.

Mr. McNerney pointed out that the studies cover a wide variety of topics and "should supply policy decision makers with useful information for arriving at meaningful decisions." He said the studies themselves are a "sign of the times," reflecting consumer interest in health administration.

John Hanna, general counsel, Health Insurance Association of America, struck out at community rating: "It would appear that for community rating methods to operate effectively a monopoly on the part of one insurance carrier in any one community is virtually necessary. Insurance companies are convinced that monopoly, whether private or public, should have no place in an area of such vital and personal concern as health insurance." ■

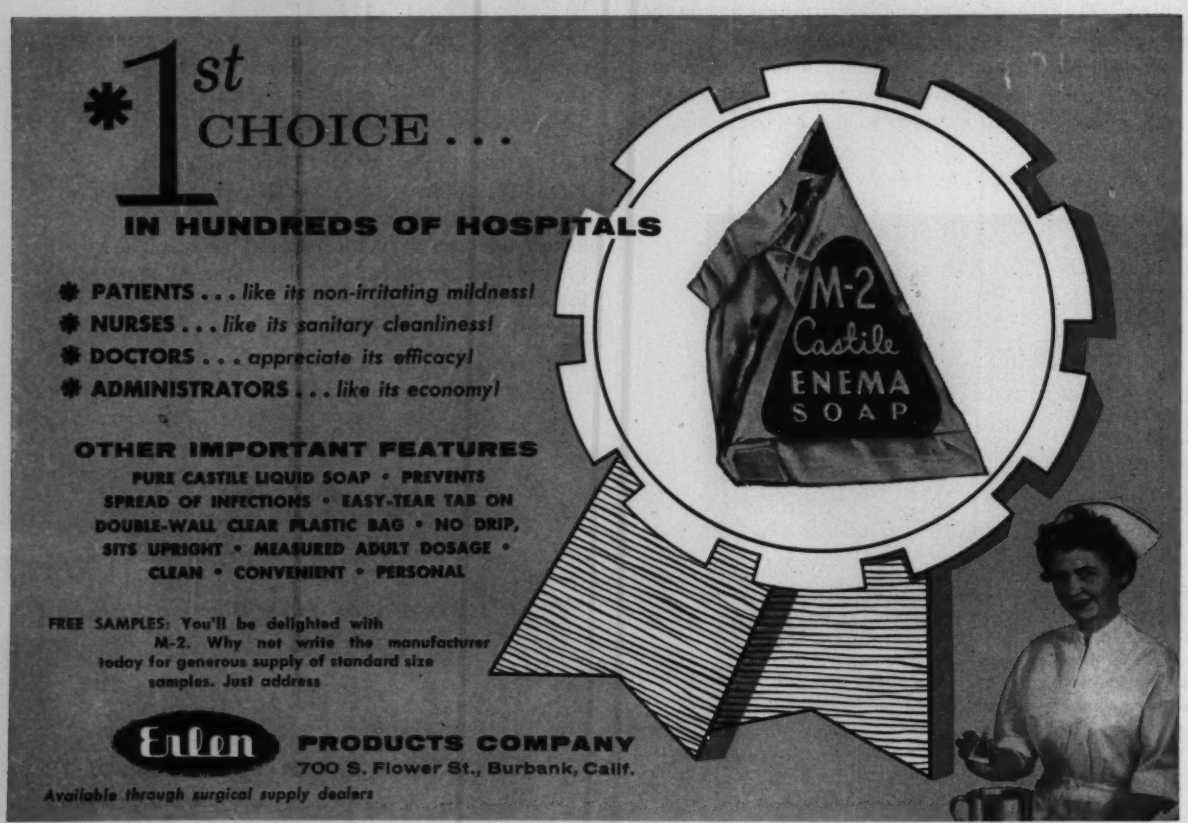
President Calls For Panel On Mental Retardation

In a statement released in mid-October regarding the need for a national plan in mental retardation, President John F. Kennedy said, "We must undertake a comprehensive and coordinated attack on the problem of mental retardation. The large number of people involved, the great cost to the nation, the striking need, the vast area of the unknown that beckons us to increase research efforts—all demand attention."

For these reasons, the statement continues, a panel of outstanding physicians, scientists, educators, lawyers, psychologists, social scientists and leaders in this field has been called together to prescribe a program of action. The panel will review and report, on or before Dec. 31, 1962, on:

1. The personnel necessary to develop and apply new knowledge. (The present shortage of personnel, such as physicians, nurses, social workers, educators and psychologists is considered to be a major problem.)

2. The major areas of concern that offer the most hope; and the means, the techniques and the private and governmental structures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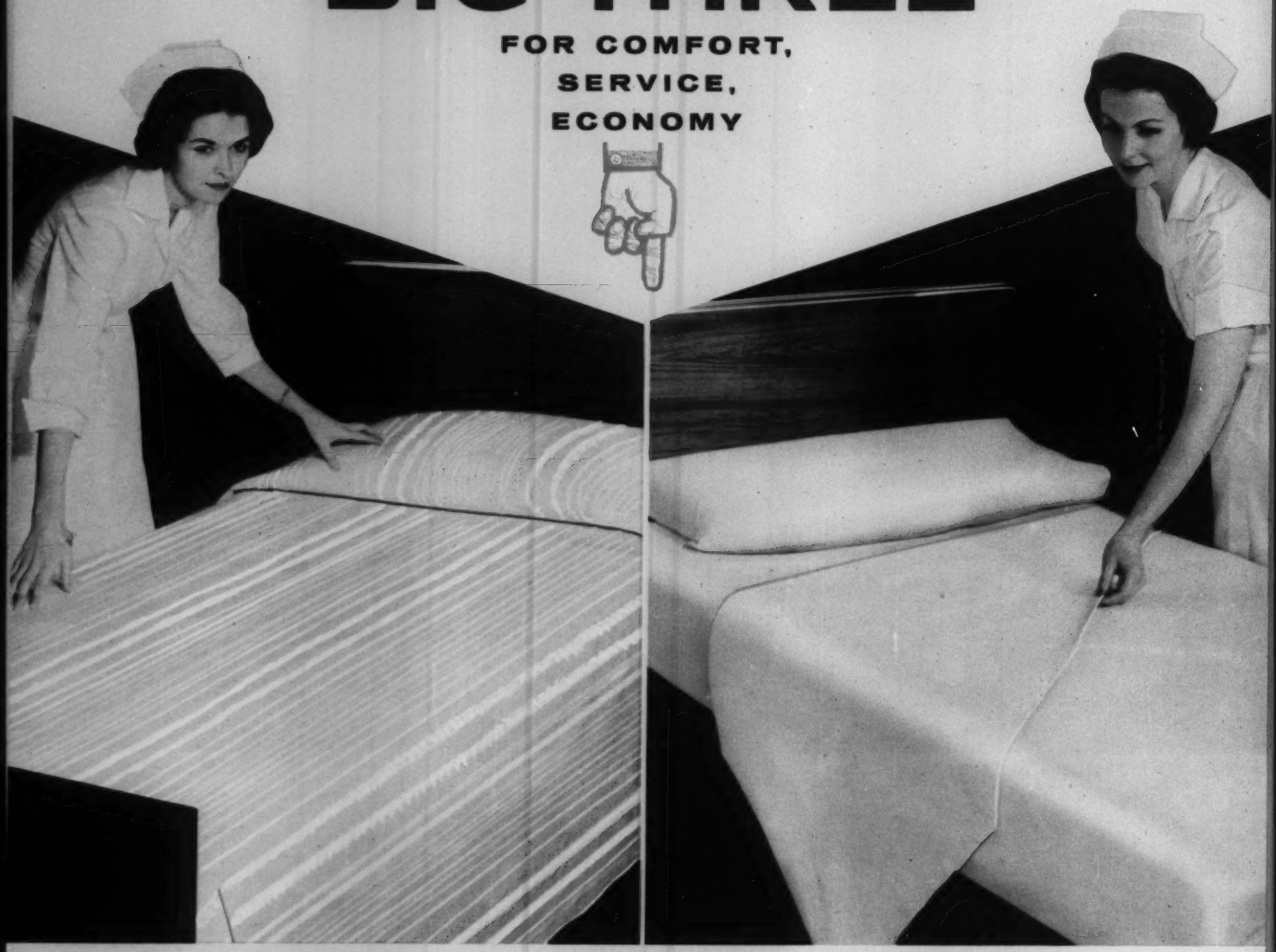

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necessary to encourage research in these areas.

3. The present programs of treatment, education and rehabilitation.

4. The relationships between the federal government, the states and private resources in their common efforts to eliminate mental retardation.

Illustrating the need for research in mental retardation, the statement pointed out that until 1954, no state health department offered any special services for mentally retarded children or their families. "The welfare services were directed largely to long-term institutional care," the statement continued. "Today almost every state has a special demonstration service or training project in mental retardation as a part of its maternal and child health service program."

"Last year," the president's statement noted, "the National Institute of Mental Health spent over $2.5 million on research, technical assistance and grants in the mental retardation area, and the National Institute of Neurological Diseases and Blindness spent over $8 million on mental retardation."

The statement pointed out that there has been an increase in the beds in residential institutions. Today more than 200,000 mentally retarded patients are in such institutions, approximately 10 per cent more than there were five years ago. "But the average waiting list continues to grow, and the quality of the services often suffers from limited budgets and salary levels." To illustrate, the statement noted that in the public institutions, there are fewer than 500 full-time physicians for 160,000 patients. ■

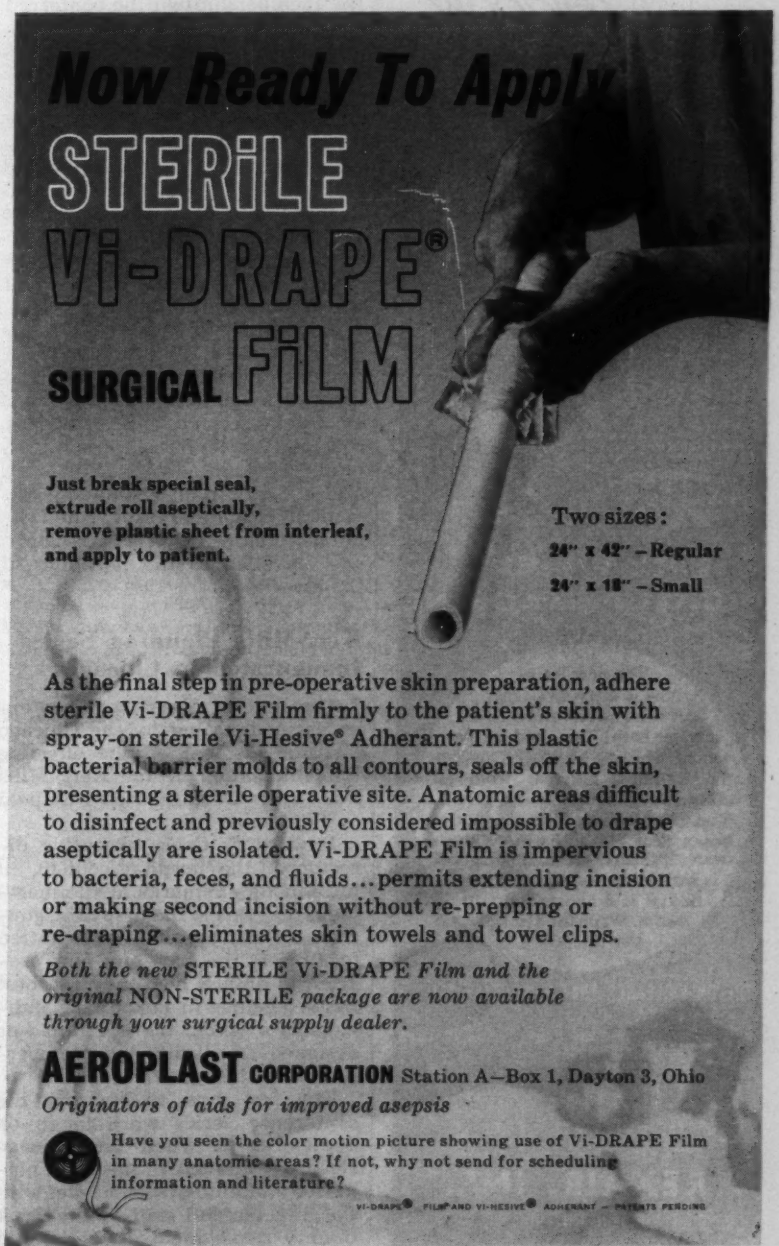
Medical Record Librarians Amend Association Bylaws

The house of delegates of the American Association of Medical Record Librarians (AAMRL), while in session October 10, voted to amend the bylaws of the association regulating qualifications for accreditation and registration.

The house met during the 33rd annual meeting of the AAMRL in Philadelphia, Oct. 9-12, 1961. Registration for the annual meeting numbered 801—the largest in the association's history.

The amendment will permit persons who have completed an educational program approved by the AAMRL education and registration committee and the executive board to qualify for either accreditation or registration. In the past, only graduates of approved schools for Medical Record Technicians and Medical Record Librarians have been eligible. This will permit experimentation with educational programs by granting authority to the education and registration committee and the executive board to qualify graduates of such programs to write the examinations.

The restriction limiting the eligibility of persons applying to write the Medical Record Librarian registration examination on the basis of experience to those employed in hospitals of 50 beds or more was also amended to include persons employed in hospitals of 25 beds or more. This brings the qualifications as to size of hospital into harmony with the eligibility requirement of the Joint Commission on Accreditation of Hospitals. Therefore, until Jan. 1, 1965, persons who are active or associate members of the association may qualify for the registration examination on the basis of experience, provided they meet both of the following qualifications: (1) Have a minimum educational background of 60 hours' credit from an accredited university or college, or graduation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from an accredited school of nursing; (2) have served successfully as a full-time medical record librarian in a hospital of 25 beds or more, or in a clinic or other distinctly medical facility, for five out of the six years immediately preceding date of application; or are accredited medical record technicians who have completed three years of satisfactory service under a registered medical record librarian.

Helen Pruitt Swift, Evanston, Ill., was elected to honorary membership in the American Association of Medical Record Librarians. The membership will be conferred at a future annual meeting of the association. This membership is in recognition of the contributions to the field made by Mrs. Swift during the time she served as the institute coordinator for the American Hospital Association and worked closely with the AAMRL in the development of its inservice educational program.

The following members were elected to the executive board of the association: President-elect, Marjorie R. Quandt, Veterans Administration, Washington, D.C.; first vice president, Gertrude Gieschen, Milwaukee (Wis.) Childrens Hospital; second vice president, Patricia Pierce, Sacred Heart Hospital, Spokane, Wash.; director, Mary Converse, Massachusetts General Hospital, Boston. Ann Ball, Johns Hopkins Hospital, Baltimore, was installed as the president of the association for 1961-62. ■

Kerr-Mills Planning Series Inaugurated in Chicago

The first in a series of conferences inaugurated by the Chicago Hospital Council on the effective implementation of the Kerr-Mills Bill in the Chicago area was held on September 18.

Howard F. Cook, executive director of the hospital council, in introductory remarks at the meeting, said "this is the first time government and hospitals have gotten together at the start of a new program to discuss how they can best work together to benefit the individual for whom the program was designed (medically indigent persons over the age of 65)".

The first steps in planning the conference series were taken on September 7, when the Chicago Hospital Council's Special Committee on Reimbursement met with the director and staff of the Cook County Department of Public Aid to discuss the mechanisms to be used by the department in implementing the Kerr-Mills program in Illinois.

Persons attending the conferences include those individuals in hospitals charged with operating the mechanics of the new program, as well as representatives of the Cook County Department of Public Aid who also have the responsibility for the operation of the program. Representatives of the Illinois Public Aid Program Commission, a state-wide agency having over-all responsibility, will also attend the meetings.

The Assistance to the Medical Indigent Aged (Kerr-Mills in Illinois) became effective August 1, and will make available approximately $10 million per year.

According to Mr. Cook, the first meeting "met with a great deal of enthusiasm from both the hospitals and governmental participants." Similar conferences are now scheduled for hospitals in various sectors of the city. ■

Sales Tax Amendments Affect Ohio Hospitals

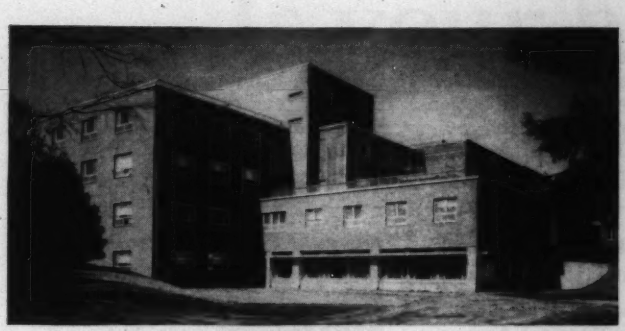
Recent changes were made in the Ohio sales tax laws affecting activities in the state's hospitals. Changes included the abolition of the use of sales tax stamps; the elimination of sales tax on prescription drugs and prosthetic devices and the exemption of "occasional" or "casual" sales from sales tax or vendor's license.

In reference to the third law, the Ohio Hospital Association stated that "sales tax and vendor's licenses on special projects and sales of hospital service groups has been a problem for years and is settled by the new law." Such events as card parties, rummage sales, white elephant sales, sales of handmade articles and socials and suppers are included under the new law. ■

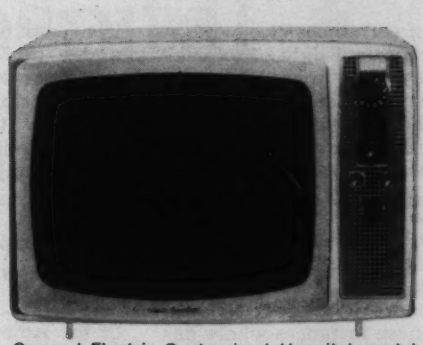
Medicare Asks Cooperation In Identification Problem

The Office for Dependents' Medical Care, Office of the Surgeon General, U.S. Army, has asked for the cooperation of hospitals and physicians in cases of still-eligible dependents of servicemen who may apply for civilian medical care, but who may not have in their possession the required proof of their eligibility.

Brig. Gen. W. D. Graham, MC, executive director of Dependents' Medical Care, explained that the



Northern Westchester Hospital, Mt. Kisco, New York, showing recently completed West Wing, incorporating every modern hospital facility. General Electric television is used throughout hospital.



General Electric Customized Hospital model, CBM 620, "Designer" TV can be used with master communications and antenna systems or as a rental unit. 19" overall diagonal. 175-sq.-in. viewable area.

Mr. Peck demonstrates the wired, remote pillow speaker which also controls volume, changes channels, turns set on and off. Set is purposely high on wall, out of the way.

"Our problem was to provide a patient with TV and not disturb others...General Electric solved it."

says Jerome F. Peck, Jr., Administrator, Northern Westchester Hospital

"Here in Mt. Kisco, we're 45 miles from New York. We don't always get the kind of TV picture we would like. After checking most of the leading brands, we found that General Electric had the style we wanted and gave us clear pictures on all channels. But the feature that really clinched it was the personal pillow speaker. This confined the sound to the individual. It meant privacy . . . allowed a patient to watch TV without disturbing his neighbors. A real boon for hospitals. It's been General Electric for us and it has worked out beautifully."

Above you see the set Mr. Peck is talking about. The slim "19" Designer, with lighted easy-to-read channel numbers. A slide switch changes the sound from pillow speaker* to cabinet speaker. Exclusive Daylight Blue picture means whiter whites, sharper contrast. UL approved. Remote control, pillow speaker and wall bracket are optional, extra. Choose from a full line of sets, some with wireless remote control. See your General Electric TV Distributor or write directly to TV Receiver Department, Room 152, General Electric Company, Syracuse, N.Y.

*Not standard equipment with a TV receiver.

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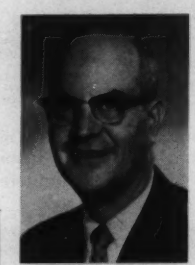
retention of certain servicemen beyond their normal date of expiration of active duty tours has posed the problem of some dependents being without valid identification cards for some time.

Brigadier General Graham has asked civilian physicians and hospitals, who recognize the identification card as the dependent's "license" to obtain authorized civilian medical care at government expense, to cooperate with the armed forces in those instances where delay occurs in obtaining the proper identification and the dependent is in need of authorized medical care under the Medicare Program.

The serviceman or his dependent is responsible for taking the action necessary to "up-date" the evidence of eligibility, but during any interim the dependent has been instructed to explain the situation to the physician and hospital authorities, and to produce some tangible evidence, such as allotment checks, official orders or directives, or personal letters which state the pertinent facts. ■

AHA Appoints John Kinsey Public Information Director

Edwin L. Crosby, M.D., director of the American Hospital Association, has announced the appointment of John R. Kinsey as director of the Public Information Division of the American Hospital Association, effective November 1.



MR. KINSEY

Mr. Kinsey will succeed Daniel S. Schechter, who was recently named deputy director of the Association's Department of Publications and Communications, of which the Public Information Division is a part.

For the past 10 years Mr. Kinsey has been director of public relations at Chicago Wesley Memorial Hospital. Prior to that he was publicity director of Northwestern University, Evanston, Ill.; publicity director of the Millers National Federation, Chicago; associate editor of *Popular Mechanics* Magazine, Chicago, and a reporter for the Chicago *Daily News*.

He attended Knox College, Galesburg, Ill., and the University of Illinois. ■

Hospital in Pittsburgh Plans Unique Outpatient Center

A new idea in medical and health services has been initiated by St. John's General Hospital, Pittsburgh.

This fall the hospital began construction of a $1.2 million "emergency, diagnostic and health center" in the North Hills of Pittsburgh, about 10 miles from the main hospital buildings. According to St. John's officials, the center will supplement inpatient facilities of existing hospitals and encourage more efficient and less costly service.

The plan has been approved by the Pennsylvania State Department of Public Welfare, and $372,000 in federal aid has been allocated for the project.

The plan has been approved by the Hospital Planning Association of Allegheny County. This association urged St. John's General Hospital to develop a health center as a new method of meeting the

How to raise funds and influence communities...

A HOSPITAL fund raising campaign that reaches its financial objective but endangers its respect and standing in the community is *not* a truly successful campaign. At least not by WARD, DRESHMAN & REINHARDT standards. Through more than 400 hospital fund raising campaigns conducted during the past 50 years, this firm has developed techniques which have proven over and over again that maximum financial support can be achieved while simultaneously building community good will. And the fact that more than 8 out of 10 campaigns conducted by this firm are "repeat" endeavors for clients wholly satisfied on previous appeals, is excellent evidence that fund raising programs directed by our firm can do more than just raise funds. May we tell you about our services? *Consultation without cost or obligation.*

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Is your hospital PR* program making friends out of patients?

*Over 4,000 hospitals have made Dermassage, America's foremost non-alcoholic body rub, an effective instrument for improving and expanding Patient Relations.**

Hospital administrators and their staffs are rightfully concerned about the increasingly heavy burden placed upon their facilities and the resulting effects this has on patient relations.

Good patient relations is everyone's problem. For this reason, the makers of Dermassage are pleased to offer this practical and proved program for your serious consideration.

The patient wants to be handled with care. Certainly he expects to be provided with the best possible facilities, experienced professional talent and modern medication. But he looks for something more: to be treated *gently*. This is important to him—and in the long run—important to your hospital.

In over 4,000 hospitals, the accepted way to demonstrate this gentle care and attention to patient comfort is with a regular Dermassage massage. As an integral part of your patient skin care program, Dermassage offers the hospital and patient alike a number of significant advantages.

Dermassage is popular with patients. They frequently mention its use to friends, reflecting favorably on your patient handling techniques. Dermassage has the fresh, pleasant aroma of natural menthol (no perfumed scent to annoy the sensitive patient). It's non-greasy. Can't stain bed clothes. And Dermassage contains no alcohol to dry and irritate the skin. Helps prevent bedsores and sheet burn. As you'd expect, Dermassage maintains an excellent bacteriostatic activity against common skin bacteria.

And Dermassage is economical. Replaces both alcohol and talcum, saving nurses' valuable time. Popular sizes available locally for immediate delivery. The name and picture of your hospital can be beautifully inscribed on your Dermassage bottles at no extra cost. This, too, is excellent public relations and highly ethical, of course. Picture can be made from photo or your letterhead.

Why not consider adding this gentle, effective patient protection to your daily routine. Dermassage is good P.R. Over 4,000 hospitals can't be wrong!

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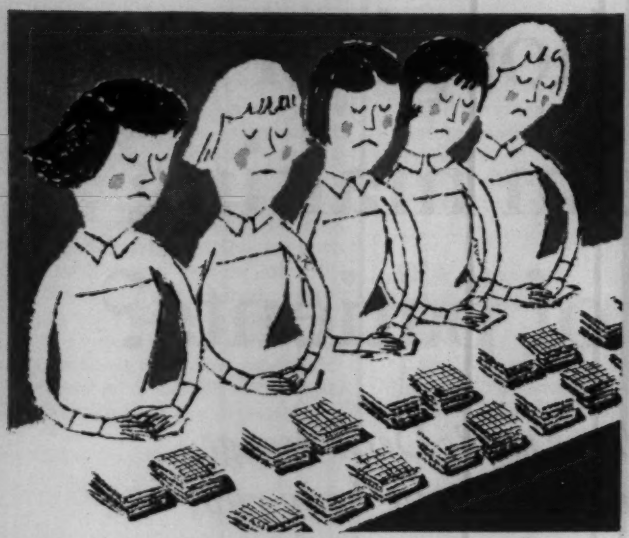
☐ I enclose our hospital's picture for free sample layout of bottle imprint.

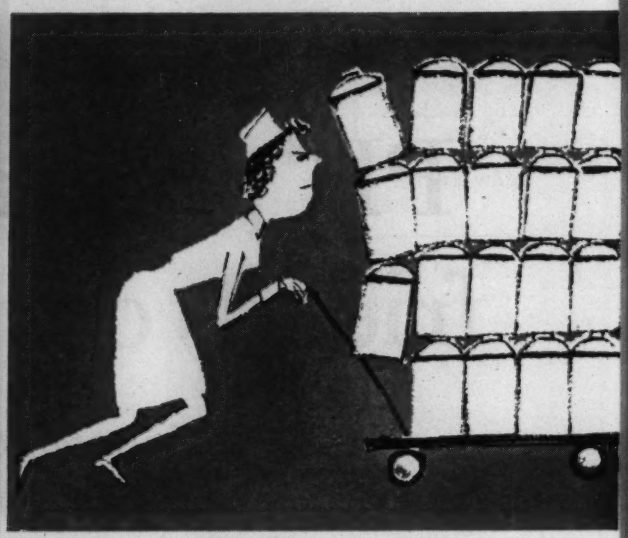
Name_____ Position_____

Hospital_____ No. of Beds_____

Address_____

City_____ Zone____ State_____





Don't waste time with rolling your own dressings . . . . . packing each one into cans for sterilization . . . . . .

Now–sterile abdominal pad in S-E Pack...for complete sterility all the way to the wound

(A LOW-COST, COMMON-SENSE DEFENSE AGAINST STAPH INFECTIONS)

In one simple motion Curity S-E Pack opens (without scissors or string) and applies a totally aseptic pad to the patient—never touching torn, unsterile edges.

The S-E Pack is a significant advance in aseptic dressing technique. And now it's available in an abdominal pad.

The new S-E Pack offers the ultimate in ease of application. It enables you to deliver a totally sterile dressing to the wound—without fumbling, dropping or contaminating the pad with fingers or pack edges.

Another distinct benefit of the S-E Pack is its economy. A saving of time and action, plus fewer dressings. You can use one pack instead of a stack.

1. Simply peel back one flap and dressing is ready to apply.
2. Dressing is tucked in pocket . . . easy to reach with one hand.
3. Other hand is free to apply sterile dressing to the wound.

Sterile abdominal pads come in three sizes: 9″ x 5″ —7½″ x 8″—10″ x 8″. Cover sponges and gauze sponges are also available in S-E Pack, in a variety of sizes. Call your Curity representative for complete details about the improved asepsis and outstanding economy of **S-E Pack.**

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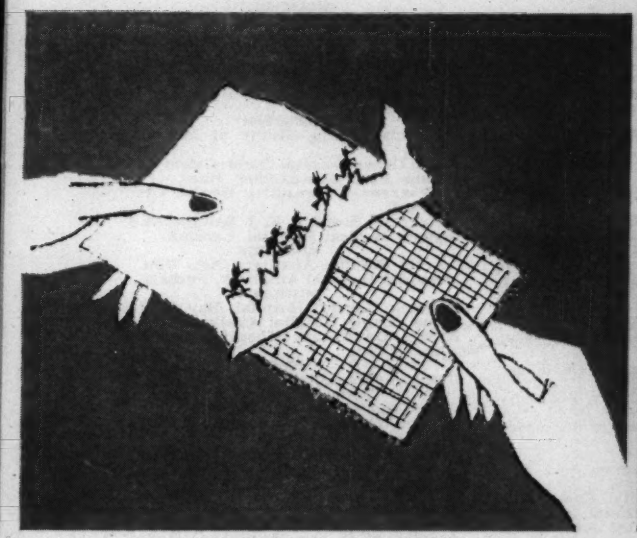
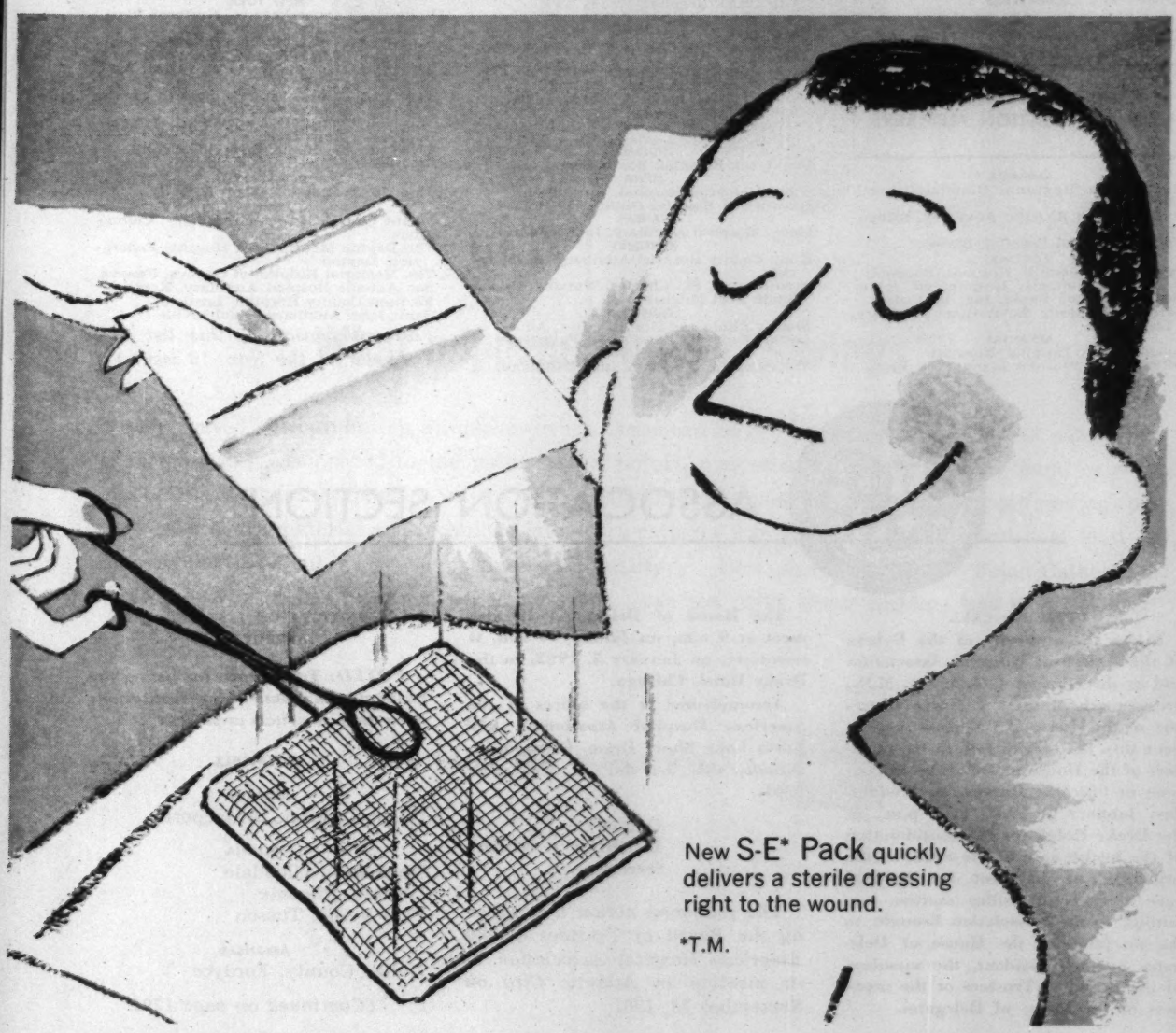


. . . . prepacks that contaminate dressings when removed . . . . . or ones that take 3 hands to open



New S-E* Pack quickly delivers a sterile dressing right to the wound.

*T.M.

health needs in the growing suburbs.

St. John's North Hills Center will be available to all physicians, and patients may be transferred to any other hospital. The center will not have inpatient facilities other than its around-the-clock emergency department. Other services will include:

- Diagnostic services, including x-ray, laboratory, electrocardiogram and basal metabolism service available on a 24-hour basis.
- Community health services, such as a well-baby clinic, child guidance center and maternity center.
- Rehabilitation services on an outpatient basis for many types of illnesses.
- County Health Department offices, facilities for mass inoculations, and a disaster center able to handle 100 casualties.
- Offices for 22 doctors and 2 dentists. ■

CURRENT LISTINGS OF NEW ASSOCIATION MEMBERS

ALABAMA
Birmingham Regional Hospital Council, Birmingham.
North Jackson Hospital Auxiliary, Bridgeport.
Choctaw General Hospital, Butler.

ARIZONA
Maryvale Community Hospital, Phoenix.
St. Johns Community Hospital, St. Johns.
Southwest Blood Banks, Inc., Scottsdale.
State Tuberculosis Sanatorium Auxiliary, Tempe.

ARKANSAS
Dallas County Hospital, Fordyce.
Jefferson Hospital Auxiliary, Pine Bluff.

CALIFORNIA
San Gorgonio Pass Memorial Hospital, Banning.
Fairview State Hospital, Costa Mesa.
Community Hospital, Lodi.
Community Hospital Auxiliary, Lodi.
Tri-City Hospital, Oceanside.
Presbyterian Medical Center Auxiliary, San Francisco.
Saint Joseph's Hospital Auxiliary, San Francisco.
Hillhaven Convalescent Hospital, San Rafael.
Santa Paula Memorial Hospital, Santa Paula.
Warrack Medical Center, Santa Rosa.

DISTRICT OF COLUMBIA
American Society of Hospital Pharmacists, Washington.
Southeast Community Hospital, Washington.

FLORIDA
Cape Canaveral Hospital, Cocoa Beach.
West Volusia County Hospital Auxiliary, De Land.
University of Florida Hospital Auxiliary, Gainesville.
Hope Haven Hospital Auxiliary, Jacksonville.
River Garden Hebrew Home for the Aged, Jacksonville.
Division Hospital, Lake City.
Fishermen's Hospital, Marathon.

GEORGIA
R. T. Jones Memorial Hospital, Canton.
Heard County Memorial Hospital, Franklin.
Clinch Memorial Hospital Auxiliary, Homerville.
804th USAF Hospital, Hunter AFB.
3550th USAF Hospital, Moody AFB.
Coweta General Hospital, Newman.

ILLINOIS
Auxiliary of Walther Memorial Hospital, Chicago.
Central Community Hospital, Chicago.
Doctors General Hospital, Chicago.
Morris H. Kreeger, M.D., Hospital Consultant, Chicago.
Patterson Nursing and Rehabilitation Home, Oak Park.

INDIANA
Dor-A-Lin Hospital, South Bend.

IOWA
Klein Memorial Hospital, Burlington.
Broadlawns Hospital Guild, Des Moines.

KANSAS
Mercy Hospital Auxiliary, Independence.

KENTUCKY
Knox County Hospital Auxiliary, Barbourville.
Auxiliary of St. Charles' Nursing Home, South Fort Mitchell.

LOUISIANA
Sharoy Clinic and Hospital, Inc., Amite.
Cotton Valley Clinic, Cotton Valley.

MARYLAND
The House in the Pines, Inc., Baltimore.

MASSACHUSETTS
Longwood Hospital, Boston.
Auxiliary of The Falmouth Hospital, Falmouth.
Framingham Union Hospital Aid Association, Framingham.
Doctors Hospital of Worcester, Inc., Worcester.

MICHIGAN
Provincial House—Sisters of Mercy, Detroit.
Maple Grove Hospital Guild, Grand Rapids.
Oceana Hospital Auxiliary, Hart.
McPherson Community Health Center, Howell.
56th USAF Hospital, K. I. Sawyer AFB.
Ingham Medical Hospital, Lansing.

MINNESOTA
Loretto Hospital Auxiliary, New Ulm.
Memorial Hospital Auxiliary, Perham.

MISSISSIPPI
Hancock General Hospital, Bay St. Louis.
Stone County Hospital Auxiliary, Wiggins.
King's Daughters Hospital Auxiliary, Yazoo City.

MISSOURI
Chillicothe Hospital, Chillicothe.
Jefferson Memorial Hospital, Festus.
Swope Ridge Hospital, Kansas City.
Cardinal Glennon Hospital Guild, St. Louis.

NEBRASKA
Pringle Memorial Hospital, Benkelman.
Webster County Community Hospital, Red Cloud.

NEVADA
Woman's Hospital, Las Vegas.

NEW JERSEY
Auxiliary of the Municipal Hospital, Camden.

NEW YORK
Volunteer Service League—Northern Westchester Hospital, Mount Kisco.
Auxiliary of the Institute of Physical Medicine and Rehabilitation, New York.
Auxiliary of University Hospital, New York.
Equitable Life Assurance Society of the United States, New York.
Muscular Dystrophy Associations of America, Inc., New York.
Clear Nursing Home, Rockville Centre.
Community Hospital, Stamford.

NORTH DAKOTA
32nd USAF Hospital, Minot AFB.

OHIO
Mount Carmel Hospital Auxiliary, Columbus.
The Dayton Metropolitan Hospital Federation, Dayton.
The Memorial Hospital of Geneva, Geneva.
San Antonio Hospital Auxiliary, Kenton.
Madison County Hospital, London.
Saint John Auxiliary, Steubenville.

(A continuation of this list will appear in the Nov. 16 issue.)

ASSOCIATION SECTION

OFFICIAL CALL

Under the authority of the Bylaws of the American Hospital Association and by direction of Jack Masur, M.D., president, I, Maurice J. Norby, secretary of the House of Delegates, hereby issue this, the official call, to the members of the House of Delegates to convene in Chicago, Illinois, on Wednesday, January 3, 1962, at 2 p.m., in the Drake Hotel, for the consideration of the health care of the aged, of the principles of payment for hospital care and of any other matters pertaining to the Association brought to the attention of the House of Delegates by the president, the members of the Board of Trustees or the members of the House of Delegates.

The House of Delegates will also meet at 9 a.m. on January 4 and, if necessary, on January 5, 1962, in the Drake Hotel, Chicago.

Accomplished at the offices of the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Illinois, this 1st day of November 1961.

(signed)
MAURICE J. NORBY
Secretary

The following action was taken by the Board of Trustees of the American Hospital Association at its meeting in Atlantic City on September 23, 1961.

COMMITTEE ON LISTINGS AND APPROVALS

VOTED: To approve for listing the hospitals and inpatient care institutions other than hospitals as shown:

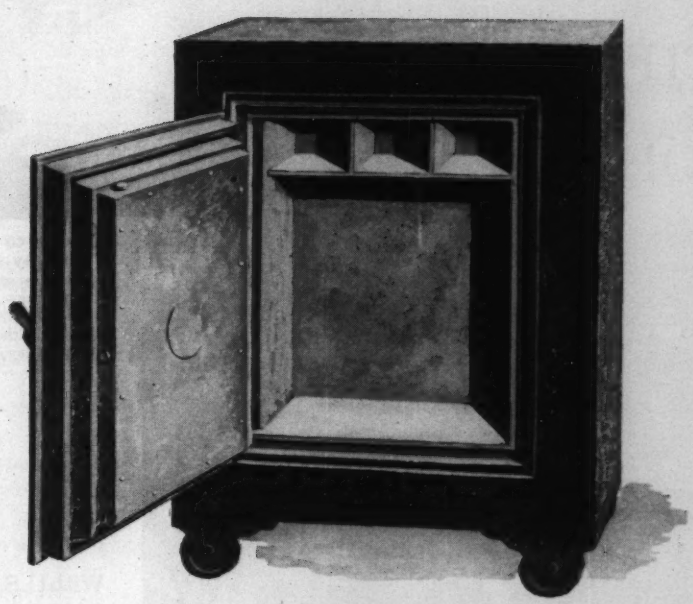
HOSPITALS

ALABAMA
North Jackson, Bridgeport

ARIZONA
Northwest, Glendale
Doctors, Phoenix
Palo Verde, Tucson

ARKANSAS
Dallas County, Fordyce

(Continued on page 129)



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SINCE 1907

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3. You invest without risk under a U. S. Government guarantee.
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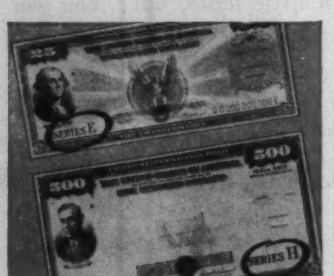
5. You can get your money with interest any time you need it.
6. You save more than money—you buy shares in a stronger America.

You save more than money with U.S. Savings Bonds



Growth or income—take your choice. E Bonds grow one-third bigger in 7¾ years. H Bonds interest comes to you by check every six months for 10 years. Both types pay a sound return: 3¼%, compounded semi-annually, when held to maturity.

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Pacoima Memorial Lutheran, Pacoima
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Sierra View District, Porterville
South Bay, Redondo Beach
Arden Community, Sacramento
College Park, San Diego
Doctors' Hospital of San Leandro, San Leandro
Sierra Vista, San Luis Obispo
Santa Ana Community, Santa Ana

COLORADO

Brighton Community, Brighton

CONNECTICUT

Hartford Municipal Hospital and Health Center, Hartford

FLORIDA

Abbey Medical Center and Hospital, Miami
North District, Pompano Beach

GEORGIA

DeKalb General, Decatur
Morgan Memorial, Madison
Gilman, St. Mary's
Houston County, Warner Robins

IDAHO

Cassia Memorial, Burley
Coeur D'Alene General, Coeur D'Alene
Minidoka Memorial, Rupert

ILLINOIS

Northwest Community, Arlington Heights
Holy Family, Des Plaines
Edward A. Utlaut Memorial, Greenville
Harrisburg, Harrisburg

INDIANA

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Witham Memorial, Lebanon
Student Health Center, West Lafayette

IOWA

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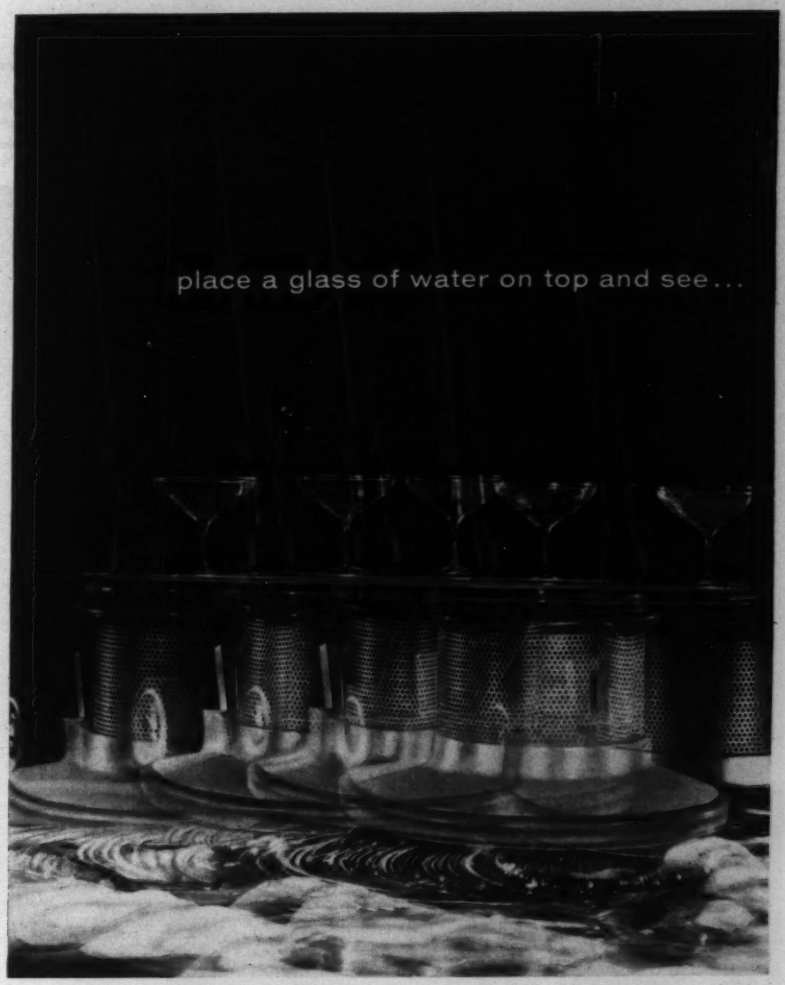
Eldora Memorial, Eldora
Forest City Municipal, Forest City
Jackson County Public, Maquoketa
Madison County Memorial, Winterset

KANSAS

Lane County, Dighton
Anderson County, Garnett
Sheridan County, Hoxie
St. John's Leavenworth

(Continued on page 130)



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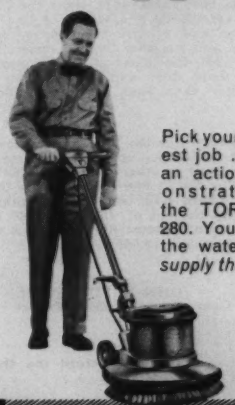

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STATEMENT REQUIRED BY THE ACT OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, JULY 2, 1946 and JUNE 11, 1960 (74 Stat. 208) SHOWING THE OWNERSHIP, MANAGEMENT, AND CIRCULATION OF HOSPITALS, Journal of the American Hospital Association, published twice a month at Chicago, Illinois for October 1, 1961.

1. The names and addresses of the publisher, editor, managing editor, and business managers are:

Publisher: American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Illinois.

Editor: James E. Hague, 840 North Lake Shore Drive, Chicago 11, Illinois.

Managing editor: Rex N. Olsen, 840 North Lake Shore Drive, Chicago 11, Illinois.

Controller and Asst. Treas.: John E. Sullivan, 840 North Lake Shore Drive, Chicago 11, Illinois

2. The owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 per cent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual member, must be given.)

American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Illinois.

3. The known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.)

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4. Paragraphs 2 and 3 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting; also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner.

5. The average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the 12 months preceding the date shown above was: (This information is required by the act of June 11, 1960 to be included in all statements regardless of frequency of issue.) 19,669.

JOHN E. SULLIVAN
Controller and Asst. Treas.

Sworn to and subscribed before me this 30th day of September, 1961.

[SEAL]

NANCY SULLIVAN
Notary Public.

(My commission expires October 26, 1963.)

Ness County, Ness City
Osborne Memorial, Osborne
Miami County, Paola
Smith County Memorial, Smith Center

KENTUCKY

Adair Memorial, Columbia
Louisville Marine Hospital for the Treatment of Chronic Illness, Louisville

LOUISIANA

Sharoy Clinic and Hospital, Amite

MASSACHUSETTS

Kenmore, Boston

MINNESOTA

White Community, Aurora
Community Hospital-Nursing Home, Cannon Falls
Community Memorial, Clarkfield
Eveleth Fitzgerald Community, Eveleth
Rice County District #1, Faribault
Minnesota Valley Memorial, Le Sueur
Renville County, Olivia
Minnesota State Prison, Stillwater

MISSOURI

Thompson, Brumm and Knepper Clinic and Hospital, St. Joseph

MONTANA

Silver Bow General, Butte

NEBRASKA

Antelope Memorial, Neligh
Lutheran, Norfolk
York General, York

NEVADA

White Pine General, Ely

NEW YORK

Interboro General, Brooklyn
Fitch Sanitarium, New York
Home for Aged and Infirm Hebrews of New York, New York
Hunts Point, New York
Parkchester General, New York
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OHIO

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Southern Coos General, Bandon
Pioneer Memorial, Heppner
Blue Mountain, John Day
Medical Center, Portland

SOUTH CAROLINA

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SOUTH DAKOTA

Crippled Children's Hospital and School, Sioux Falls

TENNESSEE

Dickson General, Dickson
Fentress County General, Jamestown

TEXAS

Beaumont Infirmary, Beaumont
Beaumont Municipal, Beaumont
Jefferson County Tuberculosis, Beaumont
Sprott, Beaumont
Cuero, Cuero
Val Verde Memorial, Del Rio
Kimble, Junction
Max Mixson Memorial Clinic, Kirbyville
Medical Arts, Lamesa
Medical-Surgical, Lockney
Menard Hospital and Retirement Home, Menard
Wagner, Palacios
Halbert Clinic and Hospital, Rosebud
Grace Lutheran Sanatorium and Hospital, San Antonio
Hays County Memorial, San Marcos

UTAH

Weber County Chronic Disease, Roy

VIRGINIA

Northern Virginia Doctors', Arlington
Galax General, Galax

WASHINGTON

Lakewood General, Tacoma

WEST VIRGINA

Calhoun General, Grantsville

WYOMING

Mammoth, Yellowstone National Park

INPATIENT CARE INSTITUTIONS OTHER THAN HOSPITALS

CALIFORNIA

Hillhaven of Anaheim, Anaheim
La Jolla Hospital for Convalescents, La Jolla
Idylwood Acres Convalescent Hospital, Sunnyvale

COLORADO

Sunset Manor, Brush

CONNECTICUT

Van Doren Chronic and Convalescent Hospital, Fairfield
Saint Mary's Home, West Hartford

FLORIDA

William and Mary Nursing Hotel, St. Petersburg

ILLINOIS

Wilmar Restorium, Carmi
River Bluff Nursing Home, Rockford

INDIANA

Kueber Nursing Home, Evansville
Wilton Rest Home, South Bend
Alfran Nursing Home, Warsaw

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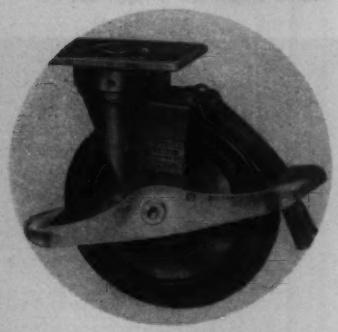

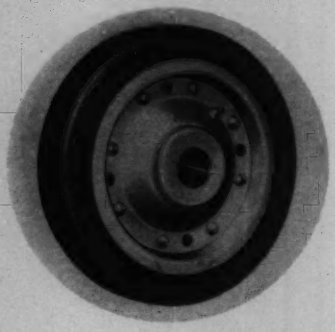

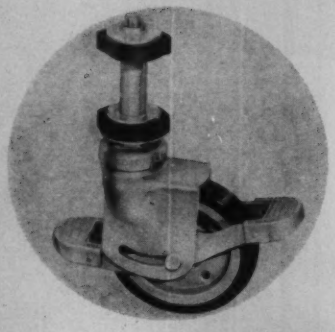

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Hopkins Nursing Home, Hopkins
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MISSOURI
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Idylease, Newfoundland
Home for Aged Sons and Daughters of Israel, Trenton

NEW YORK
Arrow Nursing Home, Flushing

OHIO
Ohio Valley Goodwill Industries Rehabilitation Center, Cincinnati
Norwalk Memorial Home, Norwalk
Greene Hill Nursing Home, Xenia

PENNSYLVANIA
Reading Institute of Rehabilitation, Reading
Rehabilitation Center at Philadelphia, Philadelphia

SOUTH DAKOTA
Dakota Nursing Home, Vermillion

UTAH
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Measuring hospital capacity for modern patient care

(Continued from page 63)

deficit space in another, unless it is potential bed capacity as thus defined.

This article presents a method for measuring hospital capacity in terms of the number of beds that can be operated safely and efficiently in the existing bed areas of a hospital and the type and amount of departmental space needed to support the normal bed capacity.

The method requires that all rooms or units of space in a hospital be measured, classified according to function and allocated to the appropriate hospital departments. The total area found in each department is then compared with nationally recognized space standards for such departments. Thus, consistent and objective judgments can be made as to the deficiency or sufficiency of the space in each department and in the hospital as a whole. Moreover, the method can be used with different standards as they change with advances in medical care.

The method can be used to provide a simple and clear picture of a hospital's space deficiencies and need for modernization to the board, the medical staff, the community and the state health department.

Of course, space is not the only factor to be considered in determining the acceptability of an existing structure. Fire hazards, structural materials and exit facilities are other important factors for which there are standards. In addition, physical condition, location, suitability of design and the location and relationship of services need to be considered. However, adequate space is so necessary for good patient care that this objective method for determining space deficiencies and space needs might well be used by hospital planning councils of state agencies in assessing priorities for funds for hospital renovation or modernization. ■

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Air-Shields, Inc. 2
Aloe Company, A. S. 114, 115
American City Bureau 24
American College of Hospital Administrators 105
American Cystoscope Makers, Inc. 28
American Gas Association 1
American Hospital Association 103, 130, 131
American Meat Institute 82
American Sterilizer Company ..... 9, 4th Cover
American Viscose Corporation 100
Arkla Air Conditioning Corporation 1

Bard, Inc., C. R. 127
Bard-Parker Co., Inc.
Div. of the Becton, Dickinson and Company 101
Barnstead Still and Sterilizer Co. 93
Bates Fabrics, Inc. 117, 118
Bauer and Black Company 124, 125
Becton, Dickinson & Company 71
Breuer Electric Mfg., Company 129

Classified Advertising 133
Clyserol Laboratories, Inc. 106
Coca-Cola Company 75
Cumerford Corporation, The 30

Dalton Co., Edward
Division of Mead Johnson and Co. 73
Darnell Corporation, Ltd. 132
Diack Controls 12
Dri-Heat Food System, Inc. 76

Economics Laboratories, Inc. 99
Edison Chemical Co., S. M. 123
Erlen Products Company 116
Ethicon, Inc. 65

Gendron Wheel Co. 97
General Electric Company
TV Receivers Department 121
Geoghegan's Wholesale Grocers &
Importers, Inc. 79
Gomco Surgical Manufacturing Corp. 11

Hall China Company ..... 3rd Cover
Hard Manufacturing Company 16
Haughton Elevator Company 34
Heiland Division
of Minneapolis-Honeywell 13
Hobart Manufacturing Company 108, 109
Hollister, Inc. 14

Ingersoll Products
Division of Borg-Warner Corp. 7

Johnson & Johnson, Hospital Division 26, 27

Kendall Co., The
Bauer and Black Division 124, 125
Kraft Foods Division of
National Dairy Products Corporation 80, 81

Legge Company, Walter 6
Lilly & Company, Eli 112
Linde Company,
Division of Union Carbide Corp. 110

Manitowoc Textiles, Inc. 8
Massengill Co., The S. E. ..... 2nd Cover
Mead Johnson and Company 73

National Fund-Raising Services, Inc. 106
Norbest Turkey Growers Association 77

Ohio Chemical & Surgical Equipment Co. 15

Parke, Davis & Company 25
Perry-Briggs Company 105
Pharmseal Laboratories 21, 22
Physicians' Record Company 102
Presco Company, Inc. 67
Procter & Gamble Company 104
Prophet Company, The 83

Rexair, Inc. 120

St. Charles Manufacturing Company 95
Smith & Underwood 12
Standard Change-Makers, Inc. 90

Taylor Company, Halsey, W. 94

Union Carbide Corp.,
Linde Company Division 110
U.S. Savings Bonds 128
Upjohn Company, The 4, 5

Van Range Company, The 69

Ward, Dreshman & Reinhardt, Inc. 122
West Chemical Products, Inc. 91
Wilson Rubber Division
Becton, Dickinson & Co. 71
Winthrop Laboratories 23
Wyeth Laboratories 32, 33

PICTURE CREDITS

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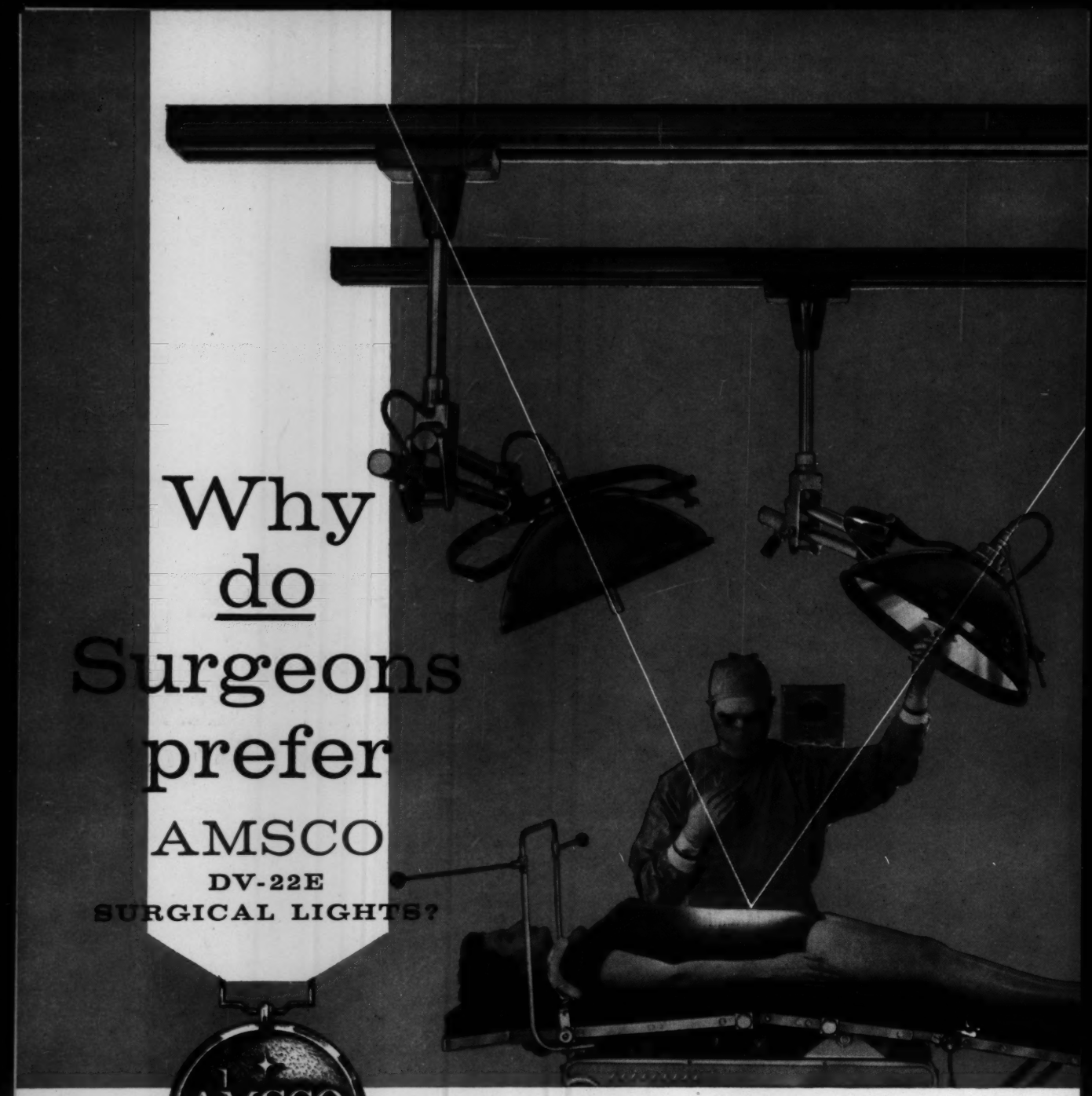

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